

## SUBCHAPTER L—HEALTH INSURANCE PORTABILITY AND RENEWABILITY FOR GROUP HEALTH PLANS

### PART 2590—RULES AND REGULATIONS FOR HEALTH INSURANCE PORTABILITY AND RENEWABILITY FOR GROUP HEALTH PLANS

#### Subpart A—Requirements Relating to Access and Renewability of Coverage, and Limitations on Preexisting Condition Exclusion Periods

Sec.

2590.701-1 Basis and scope.

2590.701-2 Definitions.

2590.701-3 Limitations on preexisting condition exclusion period.

2590.701-4 Rules relating to creditable coverage.

2590.701-5 Certification and disclosure of previous coverage.

2590.701-6 Special enrollment periods.

2590.701-7 HMO affiliation period as alternative to preexisting condition exclusion.

2590.702 Prohibiting discrimination against participants and beneficiaries based on a health status-related factor.

2590.703 Guaranteed renewability in multi-employer plans and multiple employer welfare arrangements. [Reserved]

#### Subpart B—Other Requirements

2590.711 Standards relating to benefits for mothers and newborns.

2590.712 Parity in the application of certain limits to mental health benefits.

#### Subpart C—General Provisions

2590.731 Preemption; State flexibility; construction.

2590.732 Special rules relating to group health plans.

2590.734 Enforcement. [Reserved]

2590.736 Effective dates.

AUTHORITY: Secs. 107, 209, 505, 701-703, 711, 712, and 731-734 of ERISA (29 U.S.C. 1027, 1059, 1135, 1171-1173, 1181, 1182, and 1191-1194), as amended by HIPAA (Pub. L. 104-191, 110 Stat. 1936) and NMHPA (Pub. L. 104-204, 110 Stat. 2935), and Secretary of Labor's Order No. 1-87, 52 FR 13139, April 21, 1987.

SOURCE: 62 FR 16941, Apr. 8, 1997, unless otherwise noted.

#### Subpart A—Requirements Relating to Access and Renewability of Coverage, and Limitations on Preexisting Condition Exclusion Periods

##### § 2590.701-1 Basis and scope.

(a) *Statutory basis.* This subpart implements part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended (hereinafter ERISA or the Act).

(b) *Scope.* A group health plan or health insurance issuer offering group health insurance coverage may provide greater rights to participants and beneficiaries than those set forth in this subpart. This subpart A sets forth minimum requirements for group health plans and health insurance issuers offering group health insurance coverage concerning:

(1) Limitations on a preexisting condition exclusion period.

(2) Certificates and disclosure of previous coverage.

(3) Rules relating to counting creditable coverage.

(4) Special enrollment periods.

(5) Use of an affiliation period by an HMO as an alternative to a preexisting condition exclusion.

##### § 2590.701-2 Definitions.

Unless otherwise provided, the definitions in this section govern in applying the provisions of §§ 2590.701 through 2590.734.

*Affiliation period* means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

*COBRA* definitions:

(1) *COBRA* means title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(2) *COBRA continuation coverage* means coverage, under a group health plan, that satisfies an applicable COBRA continuation provision.

(3) *COBRA continuation provision* means sections 601-608 of the Act, section 4980B of the Code (other than paragraph (f)(1) of such section 4980B insofar as it relates to pediatric vaccines), and title XXII of the PHSA.

(4) *Exhaustion of COBRA continuation coverage* means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases—

(i) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis; or

(ii) When the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual.

*Condition* means a medical condition.

*Creditable coverage* means creditable coverage within the meaning of § 2590.701-4(a).

*Enroll* means to become covered for benefits under a group health plan (i.e., when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to enroll in the plan. For this purpose, an individual who has health insurance coverage under a group health plan is enrolled in the plan regardless of whether the individual elects coverage, the individual is a dependent who becomes covered as a result of an election by a participant, or the individual becomes covered without an election.

*Enrollment date* definitions (*enrollment date* and *first day of coverage*) are set forth in § 2590.701-3(a)(2) (i) and (ii).

*Excepted benefits* means the benefits described as excepted in § 2590.732(b).

*Genetic information* means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that

identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

*Group health insurance coverage* means health insurance coverage offered in connection with a group health plan.

*Group health plan* means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

*Group market* means the market for health insurance coverage offered in connection with a group health plan. (However, certain very small plans may be treated as being in the individual market, rather than the group market; see the definition of individual market in this section.)

*Health insurance coverage* means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.

*Health insurance issuer* or *issuer* means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of the Act). Such term does not include a group health plan.

*Health maintenance organization* or *HMO* means—

(1) A federally qualified health maintenance organization (as defined in section 1301(a) of the PHSA);

(2) An organization recognized under State law as a health maintenance organization; or

(3) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

*Individual health insurance coverage* means health insurance coverage offered to individuals in the individual market, but does not include short-

term, limited duration insurance. For this purpose, short-term, limited duration insurance means health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is within 12 months of the date such contract becomes effective. Individual health insurance coverage can include dependent coverage.

*Individual market* means the market for health insurance coverage offered to individuals other than in connection with a group health plan. Unless a State elects otherwise in accordance with section 2791(e)(1)(B)(ii) of the PHSA, such term also includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

*Internal Revenue Code (Code)* means the Internal Revenue Code of 1986, as amended (Title 26, United States Code).

*Issuer* means a health insurance issuer.

*Late enrollment* definitions (*late enrollee* and *late enrollment*) are set forth in § 2590.701-3(a)(2) (iii) and (iv).

*Medical care* means amounts paid for—

(1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in paragraph (1) of this definition; and

(3) Insurance covering medical care referred to in paragraphs (1) and (2) of this definition.

*Medical condition* or *condition* means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

*Placement, or being placed, for adoption* means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The

child's placement for adoption with such person terminates upon the termination of such legal obligation.

*Plan year* means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is—

(1) The deductible/limit year used under the plan;

(2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

(4) In any other case, the plan year is the calendar year.

*Preexisting condition exclusion* means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the first day of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information that is obtained relating to an individual's health status before the individual's first day of coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

*Public health plan* means *public health plan* within the meaning of § 2590.701-4(a)(1)(ix).

*Public Health Service Act (PHSA)* means the Public Health Service Act (42 U.S.C. 201, *et seq.*).

*Significant break in coverage* means a significant break in coverage within the meaning of § 2590.701-4(b)(2)(iii).

*Special enrollment date* means a special enrollment date within the meaning of § 2590.701-6(d).

*State* means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

*State health benefits risk pool* means a State health benefits risk pool within the meaning of § 2590.701-4(a)(1)(vii).

*Waiting period* means the period that must pass before an employee or dependent is eligible to enroll under the terms of a group health plan. If an employee or dependent enrolls as a late enrollee or on a special enrollment date, any period before such late or special enrollment is not a waiting period. If an individual seeks and obtains coverage in the individual market, any period after the date the individual files a substantially complete application for coverage and before the first day of coverage is a waiting period.

[62 FR 16941, Apr. 8, 1997; 62 FR 31692, June 10, 1997]

**§ 2590.701-3 Limitations on preexisting condition exclusion period.**

(a) *Preexisting condition exclusion*—(1) *In general.* Subject to paragraph (b) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may impose, with respect to a participant or beneficiary, a preexisting condition exclusion only if the requirements of this paragraph (a) are satisfied.

(i) *6-month look-back rule.* A preexisting condition exclusion must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date.

(A) For purposes of this paragraph (a)(1)(i), medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law.

(B) For purposes of this paragraph (a)(1)(i), the 6-month period ending on the enrollment date begins on the 6-month anniversary date preceding the enrollment date. For example, for an enrollment date of August 1, 1998, the 6-month period preceding the enrollment date is the period commencing on February 1, 1998 and continuing through July 31, 1998. As another exam-

ple, for an enrollment date of August 30, 1998, the 6-month period preceding the enrollment date is the period commencing on February 28, 1998 and continuing through August 29, 1998.

(C) The rules of this paragraph (a)(1)(i) are illustrated by the following examples:

*Example 1.* (i) Individual *A* is treated for a medical condition 7 months before the enrollment date in Employer *R*'s group health plan. As part of such treatment, *A*'s physician recommends that a follow-up examination be given 2 months later. Despite this recommendation, *A* does not receive a follow-up examination and no other medical advice, diagnosis, care, or treatment for that condition is recommended to *A* or received by *A* during the 6-month period ending on *A*'s enrollment date in Employer *R*'s plan.

(ii) In this *Example 1*, Employer *R*'s plan may not impose a preexisting condition exclusion period with respect to the condition for which *A* received treatment 7 months prior to the enrollment date.

*Example 2.* (i) Same facts as *Example 1*, except that Employer *R*'s plan learns of the condition and attaches a rider to *A*'s policy excluding coverage for the condition. Three months after enrollment, *A*'s condition recurs, and Employer *R*'s plan denies payment under the rider.

(ii) In this *Example 2*, the rider is a preexisting condition exclusion and Employer *R*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *A* received treatment 7 months prior to the enrollment date.

*Example 3.* (i) Individual *B* has asthma and is treated for that condition several times during the 6-month period before *B*'s enrollment date in Employer *S*'s plan. The plan imposes a 12-month preexisting condition exclusion. *B* has no prior creditable coverage to reduce the exclusion period. Three months after the enrollment date, *B* begins coverage under Employer *S*'s plan. Two months later, *B* is hospitalized for asthma.

(ii) In this *Example 3*, Employer *S*'s plan may exclude payment for the hospital stay and the physician services associated with this illness because the care is related to a medical condition for which treatment was received by *B* during the 6-month period before the enrollment date.

*Example 4.* (i) Individual *D*, who is subject to a preexisting exclusion imposed by Employer *U*'s plan, has diabetes, as well as a foot condition caused by poor circulation and retinal degeneration (both of which are conditions that may be directly attributed to diabetes). After enrolling in the plan, *D* stumbles and breaks a leg.

(ii) In this *Example 4*, the leg fracture is not a condition related to *D*'s diabetes, even

though poor circulation in *D*'s extremities and poor vision may have contributed towards the accident. However, any additional medical services that may be needed because of *D*'s preexisting diabetic condition that would not be needed by another patient with a broken leg who does not have diabetes may be subject to the preexisting condition exclusion imposed under Employer *U*'s plan.

(ii) *Maximum length of preexisting condition exclusion (the look-forward rule).* A preexisting condition exclusion is not permitted to extend for more than 12 months (18 months in the case of a late enrollee) after the enrollment date. For purposes of this paragraph (a)(1)(ii), the 12-month and 18-month periods after the enrollment date are determined by reference to the anniversary of the enrollment date. For example, for an enrollment date of August 1, 1998, the 12-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through July 31, 1999.

(iii) *Reducing a preexisting condition exclusion period by creditable coverage.* The period of any preexisting condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage the individual has as of the enrollment date, as counted under §2590.701-4. For purposes of this subpart the phrase "days of creditable coverage" has the same meaning as the phrase "aggregate of the periods of creditable coverage" as such phrase is used in section 701(a)(3) of the Act.

(iv) *Other standards.* See §2590.702 for other standards that may apply with respect to certain benefits limitations or restrictions under a group health plan.

(2) *Enrollment definitions*—(i) *Enrollment date* means the first day of coverage or, if there is a waiting period, the first day of the waiting period.

(ii)(A) *First day of coverage* means, in the case of an individual covered for benefits under a group health plan in the group market, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy.

(B) The following example illustrates the rule of paragraph (a)(2)(ii)(A) of this section:

*Example.* (i) Employer *V*'s group health plan provides for coverage to begin on the first day of the first payroll period following the date an employee is hired and completes the applicable enrollment forms, or on any subsequent January 1 after completion of the applicable enrollment forms. Employer's *V*'s plan imposes a preexisting condition exclusion for 12 months (reduced by the individual's creditable coverage) following an individual's enrollment date. Employee *E* is hired by Employer *V* on October 13, 1998 and then on October 14, 1998 completes and files all the forms necessary to enroll in the plan. *E*'s coverage under the plan becomes effective on October 25, 1998 (which is the beginning of the first payroll period after *E*'s date of hire).

(ii) In this *Example*, *E*'s enrollment date is October 13, 1998 (which is the first day of the waiting period for *E*'s enrollment and is also *E*'s date of hire). Accordingly, with respect to *E*, the 6-month period in paragraph (a)(1)(i) would be the period from April 13, 1998 through October 12, 1998, the maximum permissible period during which Employer *V*'s plan could apply a preexisting condition exclusion under paragraph (a)(1)(ii) would be the period from October 13, 1998 through October 12, 1999, and this period would be reduced under paragraph (a)(1)(iii) by *E*'s days of creditable coverage as of October 13, 1998.

(iii) *Late enrollee* means an individual whose enrollment in a plan is a late enrollment.

(iv)(A) *Late enrollment* means enrollment under a group health plan other than on—

(1) The earliest date on which coverage can become effective under the terms of the plan; or

(2) A special enrollment date for the individual.

(B) If an individual ceases to be eligible for coverage under the plan by terminating employment, and then subsequently becomes eligible for coverage under the plan by resuming employment, only eligibility during the individual's most recent period of employment is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

(v) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

*Example 1.* (i) Employee *F* first becomes eligible to be covered by Employer *W*'s group health plan on January 1, 1999, but elects not to enroll in the plan until April 1, 1999. April 1, 1999 is not a special enrollment date for *F*.

(ii) In this *Example 1*, *F* would be a late enrollee with respect to *F*'s coverage that became effective under the plan on April 1, 1999.

*Example 2.* (i) Same as *Example 1*, except that *F* does not enroll in the plan on April 1, 1999 and terminates employment with Employer *W* on July 1, 1999, without having had any health insurance coverage under the plan. *F* is rehired by Employer *W* on January 1, 2000 and is eligible for and elects coverage under Employer *W*'s plan effective on January 1, 2000.

(ii) In this *Example 2*, *F* would not be a late enrollee with respect to *F*'s coverage that became effective on January 1, 2000.

(b) *Exceptions pertaining to preexisting condition exclusions—(1) Newborns—(i) In general.* Subject to paragraph (b)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion with regard to a child who, as of the last day of the 30-day period beginning with the date of birth, is covered under any creditable coverage. Accordingly, if a newborn is enrolled in a group health plan (or other creditable coverage) within 30 days after birth and subsequently enrolls in another group health plan without a significant break in coverage, the other plan may not impose any preexisting condition exclusion with regard to the child.

(ii) *Example.* The rule of this paragraph (b)(1) is illustrated by the following example:

*Example.* (i) Seven months after enrollment in Employer *W*'s group health plan, Individual *E* has a child born with a birth defect. Because the child is enrolled in Employer *W*'s plan within 30 days of birth, no preexisting condition exclusion may be imposed with respect to the child under Employer *W*'s plan. Three months after the child's birth, *E* commences employment with Employer *X* and enrolls with the child in Employer *X*'s plan 45 days after leaving Employer *W*'s plan. Employer *X*'s plan imposes a 12-month exclusion for any preexisting condition.

(ii) In this *Example*, Employer *X*'s plan may not impose any preexisting condition exclusion with respect to *E*'s child because the child was covered within 30 days of birth and had no significant break in coverage. This result applies regardless of whether *E*'s child is included in the certificate of creditable

coverage provided to *E* by Employer *W* indicating 300 days of dependent coverage or receives a separate certificate indicating 90 days of coverage. Employer *X*'s plan may impose a preexisting condition exclusion with respect to *E* for up to 65 days for any preexisting condition of *E* for which medical advice, diagnosis, care, or treatment was recommended or received by *E* within the 6-month period ending on *E*'s enrollment date in Employer *X*'s plan.

(2) *Adopted children.* Subject to paragraph (b)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This rule does not apply to coverage before the date of such adoption or placement for adoption.

(3) *Break in coverage.* Paragraphs (b)(1) and (2) of this section no longer apply to a child after a significant break in coverage.

(4) *Pregnancy.* A group health plan, and a health insurance issuer offering group health insurance coverage, may not impose a preexisting condition exclusion relating to pregnancy as a preexisting condition.

(5) *Special enrollment dates.* For special enrollment dates relating to new dependents, see § 2590.701-6(b).

(c) *Notice of plan's preexisting condition exclusion.* A group health plan, and a health insurance issuer offering group health insurance under the plan, may not impose a preexisting condition exclusion with respect to a participant or dependent of the participant before notifying the participant, in writing, of the existence and terms of any preexisting condition exclusion under the plan and of the rights of individuals to demonstrate creditable coverage (and any applicable waiting periods) as required by § 2590.701-5. The description of the rights of individuals to demonstrate creditable coverage includes a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and a statement that the current plan or

issuer will assist in obtaining a certificate from any prior plan or issuer, if necessary.

(Approved by the Office of Management and Budget under control number 1210-0102)

[62 FR 16941, Apr. 8, 1997; 62 FR 31670, 31692, June 10, 1997, as amended at 62 FR 35905, July 2, 1997]

**§ 2590.701-4 Rules relating to creditable coverage.**

(a) *General rules*—(1) *Creditable coverage*. For purposes of this section, except as provided in paragraph (a)(2) of this section, the term *creditable coverage* means coverage of an individual under any of the following:

(i) A group health plan as defined in § 2590.701-2.

(ii) Health insurance coverage as defined in § 2590.701-2 (whether or not the entity offering the coverage is subject to part 7 of subtitle B of title I of the Act, and without regard to whether the coverage is offered in the group market, the individual market, or otherwise).

(iii) Part A or B of title XVIII of the Social Security Act (Medicare).

(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

(v) Title 10 U.S.C. chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of title 10 U.S.C. chapter 55, *uniformed services* means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool. For purposes of this section, a State health benefits risk pool means—

(A) An organization qualifying under section 501(c)(26) of the Code;

(B) A qualified high risk pool described in section 2744(c)(2) of the PHSA; or

(C) Any other arrangement sponsored by a State, the membership composition of which is specified by the State

and which is established and maintained primarily to provide health insurance coverage for individuals who are residents of such State and who, by reason of the existence or history of a medical condition—

(1) Are unable to acquire medical care coverage for such condition through insurance or from an HMO, or

(2) Are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.

(viii) A health plan offered under title 5 U.S.C. chapter 89 (the Federal Employees Health Benefits Program).

(ix) A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, county, or other political subdivision of a State that provides health insurance coverage to individuals who are enrolled in the plan.

(x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(2) *Excluded coverage*. Creditable coverage does not include coverage consisting solely of coverage of excepted benefits (described in § 2590.732).

(3) *Methods of counting creditable coverage*. For purposes of reducing any preexisting condition exclusion period, as provided under § 2590.701-3(a)(1)(iii), a group health plan, and a health insurance issuer offering group health insurance coverage, determines the amount of an individual's creditable coverage by using the standard method described in paragraph (b) of this section, except that the plan, or issuer, may use the alternative method under paragraph (c) of this section with respect to any or all of the categories of benefits described under paragraph (c)(3) of this section.

(b) *Standard method*—(1) *Specific benefits not considered*. Under the standard method, a group health plan, and a health insurance issuer offering group health insurance coverage, determines the amount of creditable coverage without regard to the specific benefits included in the coverage.

(2) *Counting creditable coverage*—(i) *Based on days*. For purposes of reducing the preexisting condition exclusion period, a group health plan, and a health

insurance issuer offering group health insurance coverage, determines the amount of creditable coverage by counting all the days that the individual has under one or more types of creditable coverage. Accordingly, if on a particular day, an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Further, any days in a waiting period for a plan or policy are not creditable coverage under the plan or policy.

(ii) *Days not counted before significant break in coverage.* Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(iii) *Definition of significant break in coverage.* A significant break in coverage means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. (See section 731(b)(2)(iii) of the Act and section 2723(b)(2)(iii) of the PHSA which exclude from preemption State insurance laws that require a break of more than 63 days before an individual has a significant break in coverage for purposes of State law.)

(iv) *Examples.* The following examples illustrate how creditable coverage is counted in reducing preexisting condition exclusion periods under this paragraph (b)(2):

*Example 1.* (i) Individual *A* works for Employer *P* and has creditable coverage under Employer *P*'s plan for 18 months before *A*'s employment terminates. *A* is hired by Employer *Q*, and enrolls in Employer *Q*'s group health plan, 64 days after the last date of coverage under Employer *P*'s plan. Employer *Q*'s plan has a 12-month preexisting condition exclusion period.

(ii) In this *Example 1*, because *A* had a break in coverage of 63 days, Employer *Q*'s plan may disregard *A*'s prior coverage and *A* may be subject to a 12-month preexisting condition exclusion period.

*Example 2.* (i) Same facts as *Example 1*, except that *A* is hired by Employer *Q*, and enrolls in Employer *Q*'s plan, on the 63rd day after the last date of coverage under Employer *P*'s plan.

(ii) In this *Example 2*, *A* has a break in coverage of 62 days. Because *A*'s break in coverage is not a significant break in coverage,

Employer *Q*'s plan must count *A*'s prior creditable coverage for purposes of reducing the plan's preexisting condition exclusion period as it applies to *A*.

*Example 3.* (i) Same facts as *Example 1*, except that Employer *Q*'s plan provides benefits through an insurance policy that, as required by applicable State insurance laws, defines a significant break in coverage as 90 days.

(ii) In this *Example 3*, the issuer that provides group health insurance to Employer *Q*'s plan must count *A*'s period of creditable coverage prior to the 63-day break.

*Example 4.* (i) Same facts as *Example 3*, except that Employer *Q*'s plan is a self-insured plan, and, thus, is not subject to State insurance laws.

(ii) In this *Example 4*, the plan is not governed by the longer break rules under State insurance law and *A*'s previous coverage may be disregarded.

*Example 5.* (i) Individual *B* begins employment with Employer *R* 45 days after terminating coverage under a prior group health plan. Employer *R*'s plan has a 30-day waiting period before coverage begins. *B* enrolls in Employer *R*'s plan when first eligible.

(ii) In this *Example 5*, *B* does not have a significant break in coverage for purposes of determining whether *B*'s prior coverage must be counted by Employer *R*'s plan. *B* has only a 44-day break in coverage because the 30-day waiting period is not taken into account in determining a significant break in coverage.

*Example 6.* (i) Individual *C* works for Employer *S* and has creditable coverage under Employer *S*'s plan for 200 days before *C*'s employment is terminated and coverage ceases. *C* is then unemployed and does not have any creditable coverage for 51 days before being hired by Employer *T*. Employer *T*'s plan has a 3-month waiting period. *C* works for Employer *T* for 2 months and then terminates employment. Eleven days after terminating employment with Employer *T*, *C* begins working for Employer *U*. Employer *U*'s plan has no waiting period, but has a 6-month preexisting condition exclusion period.

(ii) In this *Example 6*, *C* does not have a significant break in coverage because, after disregarding the waiting period under Employer *T*'s plan, *C* had only a 62-day break in coverage (51 days plus 11 days). Accordingly, *C* has 200 days of creditable coverage and Employer *U*'s plan may not apply its 6-month preexisting condition exclusion period with respect to *C*.

*Example 7.* (i) Individual *D* terminates employment with Employer *V* on January 13, 1998 after being covered for 24 months under Employer *V*'s group health plan. On March 17, the 63rd day without coverage, *D* applies for a health insurance policy in the individual market. *D*'s application is accepted and the coverage is made effective May 1.



(ii) In this *Example 7*, because *D* applied for the policy before the end of the 63rd day, and coverage under the policy ultimately became effective, the period between the date of application and the first day of coverage is a waiting period and no significant break in coverage occurred even though the actual period without coverage was 107 days.

*Example 8.* (i) Same facts as *Example 7*, except that *D*'s application for a policy in the individual market is denied.

(ii) In this *Example 8*, because *D* did not obtain coverage following application, *D* incurred a significant break in coverage on the 64th day.

(v) *Other permissible counting methods—(A) Rule.* Notwithstanding any other provisions of this paragraph (b)(2), for purposes of reducing a preexisting condition exclusion period (but not for purposes of issuing a certificate under §2590.701-5), a group health plan, and a health insurance issuer offering group health insurance coverage, may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in this paragraph (b)(2), subject to the requirements of other applicable law.

(B) *Example.* The rule of this paragraph (b)(2)(v) is illustrated by the following example:

*Example.* (i) Individual *F* has coverage under Group Health Plan *Y* from January 3, 1997 through March 25, 1997. *F* then becomes covered by Group Health Plan *Z*. *F*'s enrollment date in Plan *Z* is May 1, 1997. Plan *Z* has a 12-month preexisting condition exclusion period.

(ii) In this *Example*, Plan *Z* may determine, in accordance with the rules prescribed in paragraph (b)(2) (i), (ii), and (iii) of this section, that *F* has 82 days of creditable coverage (29 days in January, 28 days in February, and 25 days in March). Thus, the preexisting condition exclusion period will no longer apply to *F* on February 8, 1998 (82 days before the 12-month anniversary of *F*'s enrollment (May 1)). For administrative convenience, however, Plan *Z* may consider that the preexisting condition exclusion period will no longer apply to *F* on the first day of the month (February 1).

(c) *Alternative method—(1) Specific benefits considered.* Under the alternative method, a group health plan, or a health insurance issuer offering group health insurance coverage, determines the amount of creditable coverage based on coverage within any category of benefits described in paragraph (c)(3)

of this section and not based on coverage for any other benefits. The plan or issuer may use the alternative method for any or all of the categories. The plan may apply a different preexisting condition exclusion period with respect to each category (and may apply a different preexisting condition exclusion period for benefits that are not within any category). The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph (b) of this section.

(2) *Uniform application.* A plan or issuer using the alternative method is required to apply it uniformly to all participants and beneficiaries under the plan or policy. The use of the alternative method is required to be set forth in the plan.

(3) *Categories of benefits.* The alternative method for counting creditable coverage may be used for coverage for the following categories of benefits—

- (i) Mental health;
- (ii) Substance abuse treatment;
- (iii) Prescription drugs;
- (iv) Dental care; or
- (v) Vision care.

(4) *Plan notice.* If the alternative method is used, the plan is required to—

(i) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure statements concerning the plan, and state this to each enrollee at the time of enrollment under the plan; and

(ii) Include in these statements a description of the effect of using the alternative method, including an identification of the categories used.

(5) *Disclosure of information on previous benefits.* See §2590.701-5(b) for special rules concerning disclosure of coverage to a plan, or issuer, using the alternative method of counting creditable coverage under this paragraph (c).

(6) *Counting creditable coverage—(i) In general.* Under the alternative method, the group health plan or issuer counts

creditable coverage within a category if any level of benefits is provided within the category. Coverage under a reimbursement account or arrangement, such as a flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code), does not constitute coverage within any category.

(ii) *Special rules.* In counting an individual's creditable coverage under the alternative method, the group health plan, or issuer, first determines the amount of the individual's creditable coverage that may be counted under paragraph (b) of this section, up to a total of 365 days of the most recent creditable coverage (546 days for a late enrollee). The period over which this creditable coverage is determined is referred to as the determination period. Then, for the category specified under the alternative method, the plan or issuer counts within the category all days of coverage that occurred during the determination period (whether or not a significant break in coverage for that category occurs), and reduces the individual's preexisting condition exclusion period for that category by that number of days. The plan or issuer may determine the amount of creditable coverage in any other reasonable manner, uniformly applied, that is at least as favorable to the individual.

(iii) *Example.* The rules of this paragraph (c)(6) are illustrated by the following example:

*Example.* (i) Individual *D* enrolls in Employer *V*'s plan on January 1, 2001. Coverage under the plan includes prescription drug benefits. On April 1, 2001, the plan ceases providing prescription drug benefits. *D*'s employment with Employer *V* ends on January 1, 2002, after *D* was covered under Employer *V*'s group health plan for 365 days. *D* enrolls in Employer *Y*'s plan on February 1, 2002 (*D*'s enrollment date). Employer *Y*'s plan uses the alternative method of counting creditable coverage and imposes a 12-month preexisting condition exclusion on prescription drug benefits.

(ii) In this *Example*, Employer *Y*'s plan may impose a 275-day preexisting condition exclusion with respect to *D* for prescription drug benefits because *D* had 90 days of creditable coverage relating to prescription drug benefits within *D*'s determination period.

(Approved by the Office of Management and Budget under control number 1210-0102)

[62 FR 16941, Apr. 8, 1997; 62 FR 31692, 31693, June 10, 1997, as amended at 62 FR 35905, July 2, 1997]

#### **§ 2590.701-5 Certification and disclosure of previous coverage.**

(a) *Certificate of creditable coverage—*

(1) *Entities required to provide certificate—*(i) *In general.* A group health plan, and each health insurance issuer offering group health insurance coverage under a group health plan, is required to furnish certificates of creditable coverage in accordance with this paragraph (a).

(ii) *Duplicate certificates not required.* An entity required to provide a certificate under this paragraph (a)(1) for an individual is deemed to have satisfied the certification requirements for that individual if another party provides the certificate, but only to the extent that information relating to the individual's creditable coverage and waiting or affiliation period is provided by the other party. For example, in the case of a group health plan funded through an insurance policy, the issuer is deemed to have satisfied the certification requirement with respect to a participant or beneficiary if the plan actually provides a certificate that includes the information required under paragraph (a)(3) of this section with respect to the participant or beneficiary.

(iii) *Special rule for group health plans.* To the extent coverage under a plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirements under this paragraph (a)(1) if any issuer offering the coverage is required to provide the certificates pursuant to an agreement between the plan and the issuer. For example, if there is an agreement between an issuer and the plan sponsor under which the issuer agrees to provide certificates for individuals covered under the plan, and the issuer fails to provide a certificate to an individual when the plan would have been required to provide one under this paragraph (a), then the issuer, but not the plan, violates the certification requirements of this paragraph (a).

(iv) *Special rules for issuers—*(A)(1) *Responsibility of issuer for coverage period.*

An issuer is not required to provide information regarding coverage provided to an individual by another party.

(2) *Example.* The rule of this paragraph (a)(1)(iv)(A) is illustrated by the following example:

*Example.* (i) A plan offers coverage with an HMO option from one issuer and an indemnity option from a different issuer. The HMO has not entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) In this *Example*, if an employee switches from the indemnity option to the HMO option and later ceases to be covered under the plan, any certificate provided by the HMO is not required to provide information regarding the employee's coverage under the indemnity option.

(B)(1) *Cessation of issuer coverage prior to cessation of coverage under a plan.* If an individual's coverage under an issuer's policy ceases before the individual's coverage under the plan ceases, the issuer is required to provide sufficient information to the plan (or to another party designated by the plan) to enable a certificate to be provided by the plan (or other party), after cessation of the individual's coverage under the plan, that reflects the period of coverage under the policy. The provision of that information to the plan will satisfy the issuer's obligation to provide an automatic certificate for that period of creditable coverage for the individual under paragraph (a)(2)(ii) and (3) of this section. In addition, an issuer providing that information is required to cooperate with the plan in responding to any request made under paragraph (b)(1) of this section (relating to the alternative method of counting creditable coverage). If the individual's coverage under the plan ceases at the time the individual's coverage under the issuer's policy ceases, the issuer must provide an automatic certificate under paragraph (a)(2)(ii) of this section. An issuer may presume that an individual whose coverage ceases at a time other than the effective date for changing enrollment options has ceased to be covered under the plan.

(2) *Example.* The rule of this paragraph (a)(1)(iv)(B) is illustrated by the following example.

*Example.* (i) A group health plan provides coverage under an HMO option and an indemnity option with a different issuer, and only allows employees to switch on each January 1. Neither the HMO nor the indemnity issuer has entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) In this *Example*, if an employee switches from the indemnity option to the HMO option on January 1, the issuer must provide the plan (or a person designated by the plan) with appropriate information with respect to the individual's coverage with the indemnity issuer. However, if the individual's coverage with the indemnity issuer ceases at a date other than January 1, the issuer is instead required to provide the individual with an automatic certificate.

(2) *Individuals for whom certificate must be provided; timing of issuance—(i) Individuals.* A certificate must be provided, without charge, for participants or dependents who are or were covered under a group health plan upon the occurrence of any of the events described in paragraph (a)(2)(ii) or (iii) of this section.

(ii) *Issuance of automatic certificates.* The certificates described in this paragraph (a)(2)(ii) are referred to as automatic certificates.

(A) *Qualified beneficiaries upon a qualifying event.* In the case of an individual who is a qualified beneficiary (as defined in section 607(3) of the Act) entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual would lose coverage under the plan in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage. A plan or issuer satisfies this requirement if it provides the automatic certificate no later than the time a notice is required to be furnished for a qualifying event under section 606 of the Act (relating to notices required under COBRA).

(B) *Other individuals when coverage ceases.* In the case of an individual who is not a qualified beneficiary entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual ceases to be covered under the plan. A

plan or issuer satisfies this requirement if it provides the automatic certificate within a reasonable time period thereafter. In the case of an individual who is entitled to elect to continue coverage under a State program similar to COBRA and who receives the automatic certificate not later than the time a notice is required to be furnished under the State program, the certificate is deemed to be provided within a reasonable time period after the cessation of coverage under the plan.

(C) *Qualified beneficiaries when COBRA ceases.* In the case of an individual who is a qualified beneficiary and has elected COBRA continuation coverage (or whose coverage has continued after the individual became entitled to elect COBRA continuation coverage), an automatic certificate is to be provided at the time the individual's coverage under the plan ceases. A plan, or issuer, satisfies this requirement if it provides the automatic certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums). An automatic certificate is required to be provided to such an individual regardless of whether the individual has previously received an automatic certificate under paragraph (a)(2)(ii)(A) of this section.

(iii) *Any individual upon request.* Requests for certificates are permitted to be made by, or on behalf of, an individual within 24 months after coverage ceases. Thus, for example, a plan in which an individual enrolls may, if authorized by the individual, request a certificate of the individual's creditable coverage on behalf of the individual from a plan in which the individual was formerly enrolled. After the request is received, a plan or issuer is required to provide the certificate by the earliest date that the plan or issuer, acting in a reasonable and prompt fashion, can provide the certificate. A certificate is required to be provided under this paragraph (a)(2)(iii) even if the individual has previously received a certificate under this paragraph (a)(2)(iii) or an automatic certificate under paragraph (a)(2)(ii) of this section.

(iv) *Examples.* The following examples illustrate the rules of this paragraph (a)(2):

*Example 1.* (i) Individual *A* terminates employment with Employer *Q*. *A* is a qualified beneficiary entitled to elect COBRA continuation coverage under Employer *Q*'s group health plan. A notice of the rights provided under COBRA is typically furnished to qualified beneficiaries under the plan within 10 days after a covered employee terminates employment.

(ii) In this *Example 1*, the automatic certificate may be provided at the same time that *A* is provided the COBRA notice.

*Example 2.* (i) Same facts as *Example 1*, except that the automatic certificate for *A* is not completed by the time the COBRA notice is furnished to *A*.

(ii) In this *Example 2*, the automatic certificate may be provided within the period permitted by law for the delivery of notices under COBRA.

*Example 3.* (i) Employer *R* maintains an insured group health plan. *R* has never had 20 employees and thus *R*'s plan is not subject to the COBRA continuation coverage provisions. However, *R* is in a State that has a State program similar to COBRA. *B* terminates employment with *R* and loses coverage under *R*'s plan.

(ii) In this *Example 3*, the automatic certificate may be provided not later than the time a notice is required to be furnished under the State program.

*Example 4.* (i) Individual *C* terminates employment with Employer *S* and receives both a notice of *C*'s rights under COBRA and an automatic certificate. *C* elects COBRA continuation coverage under Employer *S*'s group health plan. After four months of COBRA continuation coverage and the expiration of a 30-day grace period, Employer *S*'s group health plan determines that *C*'s COBRA continuation coverage has ceased due to failure to make a timely payment for continuation coverage.

(ii) In this *Example 4*, the plan must provide an updated automatic certificate to *C* within a reasonable time after the end of the grace period.

*Example 5.* (i) Individual *D* is currently covered under the group health plan of Employer *T*. *D* requests a certificate, as permitted under paragraph (a)(2)(iii) of this section. Under the procedure for Employer *T*'s plan, certificates are mailed (by first class mail) 7 business days following receipt of the request. This date reflects the earliest date that the plan, acting in a reasonable and prompt fashion, can provide certificates.

(ii) In this *Example 5*, the plan's procedure satisfies paragraph (a)(2)(iii) of this section.

(3) *Form and content of certificate*—(i) *Written certificate*—(A) *In general.* Except as provided in paragraph (a)(3)(i)(B) of this section, the certificate must be provided in writing (including any form approved by the Secretary as a writing).

(B) *Other permissible forms.* No written certificate is required to be provided under this paragraph (a) with respect to a particular event described in paragraph (a)(2) (ii) or (iii) of this section, if—

(1) An individual is entitled to receive a certificate;

(2) The individual requests that the certificate be sent to another plan or issuer instead of to the individual;

(3) The plan or issuer that would otherwise receive the certificate agrees to accept the information in this paragraph (a)(3) through means other than a written certificate (e.g., by telephone); and

(4) The receiving plan or issuer receives such information from the sending plan or issuer in such form within the time periods required under paragraph (a)(2) of this section.

(ii) *Required information.* The certificate must include the following—

(A) The date the certificate is issued;

(B) The name of the group health plan that provided the coverage described in the certificate;

(C) The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan and the name of the participant if the certificate is for (or includes) a dependent;

(D) The name, address, and telephone number of the plan administrator or issuer required to provide the certificate;

(E) The telephone number to call for further information regarding the certificate (if different from paragraph (a)(3)(ii)(D) of this section);

(F) Either—

(1) A statement that an individual has at least 18 months (for this purpose, 546 days is deemed to be 18 months) of creditable coverage, disregarding days of creditable coverage

before a significant break in coverage, or

(2) The date any waiting period (and affiliation period, if applicable) began and the date creditable coverage began; and

(G) The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate.

(iii) *Periods of coverage under certificate.* If an automatic certificate is provided pursuant to paragraph (a)(2)(ii) of this section, the period that must be included on the certificate is the last period of continuous coverage ending on the date coverage ceased. If an individual requests a certificate pursuant to paragraph (a)(2)(iii) of this section, a certificate must be provided for each period of continuous coverage ending within the 24-month period ending on the date of the request (or continuing on the date of the request). A separate certificate may be provided for each such period of continuous coverage.

(iv) *Combining information for families.* A certificate may provide information with respect to both a participant and the participant's dependents if the information is identical for each individual or, if the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.

(v) *Model certificate.* The requirements of paragraph (a)(3)(ii) of this section are satisfied if the plan or issuer provides a certificate in accordance with a model certificate authorized by the Secretary.

(vi) *Excepted benefits; categories of benefits.* No certificate is required to be furnished with respect to excepted benefits described in § 2590.732. In addition, the information in the certificate regarding coverage is not required to specify categories of benefits described in § 2590.701-4(c) (relating to the alternative method of counting creditable coverage). However, if excepted benefits are provided concurrently with other creditable coverage (so that the coverage does not consist solely of excepted benefits), information concerning the benefits may be required to

be disclosed under paragraph (b) of this section.

(4) *Procedures—(i) Method of delivery.* The certificate is required to be provided to each individual described in paragraph (a)(2) of this section or an entity requesting the certificate on behalf of the individual. The certificate may be provided by first-class mail. If the certificate or certificates are provided to the participant and the participant's spouse at the participant's last known address, then the requirements of this paragraph (a)(4) are satisfied with respect to all individuals residing at that address. If a dependent's last known address is different than the participant's last known address, a separate certificate is required to be provided to the dependent at the dependent's last known address. If separate certificates are being provided by mail to individuals who reside at the same address, separate mailings of each certificate are not required.

(ii) *Procedure for requesting certificates.* A plan or issuer must establish a procedure for individuals to request and receive certificates pursuant to paragraph (a)(2)(iii) of this section.

(iii) *Designated recipients.* If an automatic certificate is required to be provided under paragraph (a)(2)(ii) of this section, and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is permitted to provide the certificate to the designated party. If a certificate is required to be provided upon request under paragraph (a)(2)(iii) of this section and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is required to provide the certificate to the designated party.

(5) *Special rules concerning dependent coverage—(i)(A) Reasonable efforts.* A plan or issuer is required to use reasonable efforts to determine any information needed for a certificate relating to dependent coverage. In any case in which an automatic certificate is required to be furnished with respect to a dependent under paragraph (a)(2)(ii) of this section, no individual certificate is

required to be furnished until the plan or issuer knows (or making reasonable efforts should know) of the dependent's cessation of coverage under the plan.

(B) *Example.* The rules of this paragraph (a)(5) are illustrated by the following example:

*Example.* (i) A group health plan covers employees and their dependents. The plan annually requests all employees to provide updated information regarding dependents, including the specific date on which an employee has a new dependent or on which a person ceases to be a dependent of the employee.

(ii) In this *Example*, the plan has satisfied the standard in this paragraph (a)(5)(i) that it make reasonable efforts to determine the cessation of dependents' coverage and the related dependent coverage information.

(ii) *Special rules for demonstrating coverage.* If a certificate furnished by a plan or issuer does not provide the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in paragraph (c)(4) of this section for demonstrating dependent status. In addition, an individual may, if necessary, use these procedures to demonstrate that a child was enrolled within 30 days of birth, adoption, or placement for adoption. See §2590.701-3(b), under which such a child would not be subject to a preexisting condition exclusion.

(iii) *Transition rule for dependent coverage through June 30, 1998—(A) In general.* A group health plan or health insurance issuer that cannot provide the names of dependents (or related coverage information) for purposes of providing a certificate of coverage for a dependent may satisfy the requirements of paragraph (a)(3)(ii)(C) of this section by providing the name of the participant covered by the group health plan or health insurance issuer and specifying that the type of coverage described in the certificate is for dependent coverage (e.g., family coverage or employee-plus-spouse coverage).

(B) *Certificates provided on request.* For purposes of certificates provided on the request of, or on behalf of, an individual pursuant to paragraph (a)(2)(iii) of this section, a plan or issuer must make reasonable efforts to obtain and provide the names of any dependent

covered by the certificate where such information is requested to be provided. If a certificate does not include the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in paragraph (c) of this section for submitting documentation to establish that the creditable coverage in the certificate applies to the dependent.

(C) *Demonstrating a dependent's creditable coverage.* See paragraph (c)(4) of this section for special rules to demonstrate dependent status.

(D) *Duration.* This paragraph (a)(5)(iii) is only effective for certificates provided with respect to events occurring through June 30, 1998.

(6) *Special certification rules for entities not subject to part 7 of subtitle B of title I of the Act—(i) Issuers.* For special rules requiring that issuers, not subject to part 7 of subtitle B of title I of the Act, provide certificates consistent with the rules in this section, including issuers offering coverage with respect to creditable coverage described in sections 701(c)(1)(G) through (c)(1)(J) of the Act (coverage under a State health benefits risk pool, the Federal Employees Health Benefits Program, a public health plan, and a health benefit plan under section 5(e) of the Peace Corps Act), see section 2721(b)(1)(B) of the PHSA (requiring certificates by issuers offering health insurance coverage in connection with a group health plan, including a church plan or a governmental plan (including the Federal Employees Health Benefits Program (FEHBP)). In addition, see section 2743 of the PHSA applicable to health insurance issuers in the individual market. (However, this section does not require a certificate to be provided with respect to short-term limited duration insurance, as described in the definition of *individual health insurance coverage* in § 2590.701-2, that is not provided by a group health plan or issuer offering health insurance in connection with a group health plan.)

(ii) *Other entities.* For special rules requiring that certain other entities, not subject to part 7 of subtitle B of title I of the Act, provide certificates consistent with the rules in this section, see section 2791(a)(3) of the PHSA ap-

plicable to entities described in sections 2701(c)(1)(C), (D), (E), and (F) of PHSA (relating to Medicare, Medicaid, CHAMPUS, and Indian Health Service), section 2721(b)(1)(A) of the PHSA applicable to nonfederal governmental plans generally, section 2721(b)(2)(C)(ii) of the PHSA applicable to nonfederal governmental plans that elect to be excluded from the requirements of subparts 1 through 3 of part A of title XXVII of the PHSA, and section 9805(a) of the Internal Revenue Code applicable to group health plans, which includes church plans (as defined in section 414(e) of the Internal Revenue Code).

(b) *Disclosure of coverage to a plan, or issuer, using the alternative method of counting creditable coverage—(1) In general.* If an individual enrolls in a group health plan with respect to which the plan, or issuer, uses the alternative method of counting creditable coverage described in § 2590.701-4(c) the individual provides a certificate of coverage under paragraph (a) of this section, and the plan or issuer in which the individual enrolls so requests, the entity that issued the certificate (the prior entity) is required to disclose promptly to a requesting plan or issuer (the requesting entity) the information set forth in paragraph (b)(2) of this section.

(2) *Information to be disclosed.* The prior entity is required to identify to the requesting entity the categories of benefits with respect to which the requesting entity is using the alternative method of counting creditable coverage, and the requesting entity may identify specific information that the requesting entity reasonably needs in order to determine the individual's creditable coverage with respect to any such category. The prior entity is required to disclose promptly to the requesting entity the creditable coverage information so requested.

(3) *Charge for providing information.* The prior entity furnishing the information under paragraph (b) of this section may charge the requesting entity for the reasonable cost of disclosing such information.

(c) *Ability of an individual to demonstrate creditable coverage and waiting period information—(1) In general.* The rules in this paragraph (c) implement

section 701(c)(4) of the Act, which permits individuals to establish creditable coverage through means other than certificates, and section 701(e)(3) of the Act, which requires the Secretary to establish rules designed to prevent an individual's subsequent coverage under a group health plan or health insurance coverage from being adversely affected by an entity's failure to provide a certificate with respect to that individual. If the accuracy of a certificate is contested or a certificate is unavailable when needed by the individual, the individual has the right to demonstrate creditable coverage (and waiting or affiliation periods) through the presentation of documents or other means. For example, the individual may make such a demonstration when—

- (i) An entity has failed to provide a certificate within the required time period;
- (ii) The individual has creditable coverage but an entity may not be required to provide a certificate of the coverage pursuant to paragraph (a) of this section;
- (iii) The coverage is for a period before July 1, 1996;
- (iv) The individual has an urgent medical condition that necessitates a determination before the individual can deliver a certificate to the plan; or
- (v) The individual lost a certificate that the individual had previously received and is unable to obtain another certificate.

(2) *Evidence of creditable coverage—(i) Consideration of evidence.* A plan or issuer is required to take into account all information that it obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether an individual has creditable coverage and is entitled to offset all or a portion of any preexisting condition exclusion period. A plan or issuer shall treat the individual as having furnished a certificate under paragraph (a) of this section if the individual attests to the period of creditable coverage, the individual also presents relevant corroborating evidence of some creditable coverage during the period, and the individual cooperates with the plan's or issuer's efforts to verify the individual's coverage. For this purpose,

cooperation includes providing (upon the plan's or issuer's request) a written authorization for the plan or issuer to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage. While a plan or issuer may refuse to credit coverage where the individual fails to cooperate with the plan's or issuer's efforts to verify coverage, the plan or issuer may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

(ii) *Documents.* Documents that may establish creditable coverage (and waiting periods or affiliation periods) in the absence of a certificate include explanations of benefit claims (EOBs) or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

(iii) *Other evidence.* Creditable coverage (and waiting period or affiliation period information) may also be established through means other than documentation, such as by a telephone call from the plan or provider to a third party verifying creditable coverage.

(iv) *Example.* The rules of this paragraph (c)(2) are illustrated by the following example:

*Example.* (i) Individual *F* terminates employment with Employer *W* and, a month later, is hired by Employer *X*. Employer *X*'s group health plan imposes a preexisting condition exclusion of 12 months on new enrollees under the plan and uses the standard method of determining creditable coverage. *F* fails to receive a certificate of prior coverage from the self-insured group health plan maintained by *F*'s prior employer, Employer *W*, and requests a certificate. However, *F* (and Employer *X*'s plan, on *F*'s behalf) is unable to obtain a certificate from Employer *W*'s plan. *F* attests that, to the best of *F*'s knowledge, *F* had at least 12 months of continuous coverage under Employer *W*'s plan, and that the coverage ended no earlier than *F*'s termination of employment from Employer *W*. In addition, *F* presents evidence of coverage, such as an explanation of benefits



for a claim that was made during the relevant period.

(ii) In this *Example*, based solely on these facts, *F* has demonstrated creditable coverage for the 12 months of coverage under Employer *W*'s plan in the same manner as if *F* had presented a written certificate of creditable coverage.

(3) *Demonstrating categories of creditable coverage.* Procedures similar to those described in this paragraph (c) apply in order to determine an individual's creditable coverage with respect to any category under paragraph (b) of this section (relating to determining creditable coverage under the alternative method).

(4) *Demonstrating dependent status.* If, in the course of providing evidence (including a certificate) of creditable coverage, an individual is required to demonstrate dependent status, the group health plan or issuer is required to treat the individual as having furnished a certificate showing the dependent status if the individual attests to such dependency and the period of such status and the individual cooperates with the plan's or issuer's efforts to verify the dependent status.

(d) *Determination and notification of creditable coverage—(1) Reasonable time period.* In the event that a group health plan or health insurance issuer offering group health insurance coverage receives information under paragraph (a) of this section (certifications), paragraph (b) of this section (disclosure of information relating to the alternative method), or paragraph (c) of this section (other evidence of creditable coverage), the entity is required, within a reasonable time period following receipt of the information, to make a determination regarding the individual's period of creditable coverage and notify the individual of the determination in accordance with paragraph (d)(2) of this section. Whether a determination and notification regarding an individual's creditable coverage is made within a reasonable time period is determined based on the relevant facts and circumstances. Relevant facts and circumstances include whether a plan's application of a preexisting condition exclusion would prevent an individual from having access to urgent medical services.

(2) *Notification to individual of period of preexisting condition exclusion.* A plan or issuer seeking to impose a preexisting condition exclusion is required to disclose to the individual, in writing, its determination of any preexisting condition exclusion period that applies to the individual, and the basis for such determination, including the source and substance of any information on which the plan or issuer relied. In addition, the plan or issuer is required to provide the individual with a written explanation of any appeal procedures established by the plan or issuer, and with a reasonable opportunity to submit additional evidence of creditable coverage. However, nothing in this paragraph (d) or paragraph (c) of this section prevents a plan or issuer from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that—

(i) A notice of such reconsideration, as described in this paragraph (d), is provided to the individual; and

(ii) Until the final determination is made, the plan or issuer, for purposes of approving access to medical services (such as a pre-surgery authorization), acts in a manner consistent with the initial determination.

(3) *Examples.* The following examples illustrate this paragraph (d):

*Example 1.* (i) Individual *G* is hired by Employer *Y*. Employer *Y*'s group health plan imposes a preexisting condition exclusion for 12 months with respect to new enrollees and uses the standard method of determining creditable coverage. Employer *Y*'s plan determines that *G* is subject to a 4-month preexisting condition exclusion, based on a certificate of creditable coverage that is provided by *G* to Employer *Y*'s plan indicating 8 months of coverage under *G*'s prior group health plan.

(ii) In this *Example 1*, Employer *Y*'s plan must notify *G* within a reasonable period of time following receipt of the certificate that *G* is subject to a 4-month preexisting condition exclusion beginning on *G*'s enrollment date in *Y*'s plan.

*Example 2.* (i) Same facts as in *Example 1*, except that Employer *Y*'s plan determines that *G* has 14 months of creditable coverage based on *G*'s certificate indicating 14 months of creditable coverage under *G*'s prior plan.

(ii) In this *Example 2*, Employer *Y*'s plan is not required to notify *G* that *G* will not be subject to a preexisting condition exclusion.

*Example 3.* (i) Individual *H* is hired by Employer *Z*. Employer *Z*'s group health plan imposes a preexisting condition exclusion for 12 months with respect to new enrollees and uses the standard method of determining creditable coverage. *H* develops an urgent health condition before receiving a certificate of prior coverage. *H* attests to the period of prior coverage, presents corroborating documentation of the coverage period, and authorizes the plan to request a certificate on *H*'s behalf.

(ii) In this *Example 3*, Employer *Z*'s plan must review the evidence presented by *H*. In addition, the plan must make a determination and notify *H* regarding any preexisting condition exclusion period that applies to *H* (and the basis of such determination) within a reasonable time period following receipt of the evidence that is consistent with the urgency of *H*'s health condition (this determination may be modified as permitted under paragraph (d)(2) of this section).

(Approved by the Office of Management and Budget under control numbers 1210-0102 and 1210-0103)

[62 FR 16941, Apr. 8, 1997; 62 FR 31670, 31692, June 10, 1997, as amended at 62 FR 35905, July 2, 1997]

#### **§ 2590.701-6 Special enrollment periods.**

(a) *Special enrollment for certain individuals who lose coverage—(1) In general.* A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, is required to permit employees and dependents described in paragraph (a) (2), (3), or (4) of this section to enroll for coverage under the terms of the plan if the conditions in paragraph (a)(5) of this section are satisfied and the enrollment is requested within the period described in paragraph (a)(6) of this section. The enrollment is effective at the time described in paragraph (a)(7) of this section. The special enrollment rights under this paragraph (a) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

(2) *Special enrollment of an employee only.* An employee is described in this paragraph (a)(2) if the employee is eligible, but not enrolled, for coverage under the terms of the plan and, when enrollment was previously offered to the employee under the plan and was declined by the employee, the employee was covered under another

group health plan or had other health insurance coverage.

(3) *Special enrollment of dependents only.* A dependent is described in this paragraph (a)(3) if the dependent is a dependent of an employee participating in the plan, the dependent is eligible, but not enrolled, for coverage under the terms of the plan, and, when enrollment was previously offered under the plan and was declined, the dependent was covered under another group health plan or had other health insurance coverage.

(4) *Special enrollment of both employee and dependent.* An employee and any dependent of the employee are described in this paragraph (a)(4) if they are eligible, but not enrolled, for coverage under the terms of the plan and, when enrollment was previously offered to the employee or dependent under the plan and was declined, the employee or dependent was covered under another group health plan or had other health insurance coverage.

(5) *Conditions for special enrollment.* An employee or dependent is eligible to enroll during a special enrollment period if each of the following applicable conditions is met:

(i) When the employee declined enrollment for the employee or the dependent, the employee stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment. This paragraph (a)(5)(i) applies only if—

(A) The plan required such a statement when the employee declined enrollment; and

(B) The employee is provided with notice of the requirement to provide the statement in this paragraph (a)(5)(i) (and the consequences of the employee's failure to provide the statement) at the time the employee declined enrollment.

(ii)(A) When the employee declined enrollment for the employee or dependent under the plan, the employee or dependent had COBRA continuation coverage under another plan and COBRA continuation coverage under that other plan has since been exhausted; or

(B) If the other coverage that applied to the employee or dependent when enrollment was declined was not under a

COBRA continuation provision, either the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage has been terminated. For this purpose, loss of eligibility for coverage includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Thus, for example, if an employee's coverage ceases following a termination of employment and the employee is eligible for but fails to elect COBRA continuation coverage, this is treated as a loss of eligibility under this paragraph (a)(5)(ii)(B). However, loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). In addition, for purposes of this paragraph (a)(5)(ii)(B), employer contributions include contributions by any current or former employer (of the individual or another person) that was contributing to coverage for the individual.

(6) *Length of special enrollment period.* The employee is required to request enrollment (for the employee or the employee's dependent, as described in paragraph (a) (2), (3), or (4) of this section) not later than 30 days after the exhaustion of the other coverage described in paragraph (a)(5)(ii)(A) of this section or termination of the other coverage as a result of the loss of eligibility for the other coverage for items described in paragraph (a)(5)(ii)(B) of this section or following the termination of employer contributions toward that other coverage. The plan may impose the same requirements that apply to employees who are otherwise eligible under the plan to immediately request enrollment for coverage (e.g., that the request be made in writing).

(7) *Effective date of enrollment.* Enrollment is effective not later than the first day of the first calendar month

beginning after the date the completed request for enrollment is received.

(b) *Special enrollment with respect to certain dependent beneficiaries—*(1) *In general.* A group health plan that makes coverage available with respect to dependents of a participant is required to provide a special enrollment period to permit individuals described in paragraph (b) (2), (3), (4), (5), or (6) of this section to be enrolled for coverage under the terms of the plan if the enrollment is requested within the time period described in paragraph (b)(7) of this section. The enrollment is effective at the time described in paragraph (b)(8) of this section. The special enrollment rights under this paragraph (b) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

(2) *Special enrollment of an employee who is eligible but not enrolled.* An individual is described in this paragraph (b)(2) if the individual is an employee who is eligible, but not enrolled, for coverage under the terms of the plan, the individual would be a participant but for a prior election by the individual not to enroll in the plan during a previous enrollment period, and a person becomes a dependent of the individual through marriage, birth, or adoption or placement for adoption.

(3) *Special enrollment of a spouse of a participant.* An individual is described in this paragraph (b)(3) if either—

(i) The individual becomes the spouse of a participant; or

(ii) The individual is a spouse of the participant and a child becomes a dependent of the participant through birth, adoption or placement for adoption.

(4) *Special enrollment of an employee who is eligible but not enrolled and the spouse of such employee.* An employee who is eligible, but not enrolled, for coverage under the terms of the plan, and an individual who is a dependent of such employee, are described in this paragraph (b)(4) if the employee would be a participant but for a prior election by the employee not to enroll in the plan during a previous enrollment period, and either—

(i) The employee and the individual become married; or

(ii) The employee and individual are married and a child becomes a dependent of the employee through birth, adoption or placement for adoption.

(5) *Special enrollment of a dependent of a participant.* An individual is described in this paragraph (b)(5) if the individual is a dependent of a participant and the individual becomes a dependent of such participant through marriage, birth, or adoption or placement for adoption.

(6) *Special enrollment of an employee who is eligible but not enrolled and a new dependent.* An employee who is eligible, but not enrolled, for coverage under the terms of the plan, and an individual who is a dependent of the employee, are described in this paragraph (b)(6) if the employee would be a participant but for a prior election by the employee not to enroll in the plan during a previous enrollment period, and the dependent becomes a dependent of the employee through marriage, birth, or adoption or placement for adoption.

(7) *Length of special enrollment period.* The special enrollment period under paragraph (b)(1) of this section is a period of not less than 30 days and begins on the date of the marriage, birth, or adoption or placement for adoption (except that such period does not begin earlier than the date the plan makes dependent coverage generally available).

(8) *Effective date of enrollment.* Enrollment is effective—

(i) In the case of marriage, not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the plan;

(ii) In the case of a dependent's birth, the date of such birth; and

(iii) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(9) *Example.* The rules of this paragraph (b) are illustrated by the following example:

*Example.* (i) Employee A is hired on September 3, 1998 by Employer X, which has a group health plan in which A can elect to enroll either for employee-only coverage, for employee-plus-spouse coverage, or for family coverage, effective on the first day of any calendar quarter thereafter. A is married and has no children. A does not elect to join Em-

ployer X's plan (for employee-only coverage, employee-plus-spouse coverage, or family coverage) on October 1, 1998 or January 1, 1999. On February 15, 1999, a child is placed for adoption with A and A's spouse.

(ii) In this *Example*, the conditions for special enrollment of an employee with a new dependent under paragraph (b)(2) of this section are satisfied, the conditions for special enrollment of an employee and a spouse with a new dependent under paragraph (b)(4) of this section are satisfied, and the conditions for special enrollment of an employee and a new dependent under paragraph (b)(6) of this section are satisfied. Accordingly, Employer X's plan will satisfy this paragraph (b) if and only if it allows A to elect, by filing the required forms by March 16, 1999, to enroll in Employer X's plan either with employee-only coverage, with employee-plus-spouse coverage, or with family coverage, effective as of February 15, 1999.

(c) *Notice of enrollment rights.* On or before the time an employee is offered the opportunity to enroll in a group health plan, the plan is required to provide the employee with a description of the plan's special enrollment rules under this section. For this purpose, the plan may use the following model description of the special enrollment rules under this section:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

(d)(1) *Special enrollment date definition.* A special enrollment date for an individual means any date in paragraph (a)(7) or (b)(8) of this section on which the individual has a right to have enrollment in a group health plan become effective under this section.

(2) *Examples.* The rules of this section are illustrated by the following examples:

*Example 1.* (i)(A) Employer Y maintains a group health plan that allows employees to enroll in the plan either—

(I) Effective on the first day of employment by an election filed within three days thereafter;

(2) Effective on any subsequent January 1 by an election made during the preceding months of November or December; or

(3) Effective as of any special enrollment date described in this section.

(B) Employee *B* is hired by Employer *Y* on March 15, 1998 and does not elect to enroll in Employer *Y*'s plan until January 31, 1999 when *B* loses coverage under another plan. *B* elects to enroll in Employer *Y*'s plan effective on February 1, 1999, by filing the completed request form by January 31, 1999, in accordance with the special rule set forth in paragraph (a) of this section.

(ii) In this *Example 1*, *B* has enrolled on a special enrollment date because the enrollment is effective at a date described in paragraph (a)(7) of this section.

*Example 2.* (i) Same facts as *Example 1*, except that *B*'s loss of coverage under the other plan occurs on December 31, 1998 and *B* elects to enroll in Employer *Y*'s plan effective on January 1, 1999 by filing the completed request form by December 31, 1998, in accordance with the special rule set forth in paragraph (a) of this section.

(ii) In this *Example 2*, *B* has enrolled on a special enrollment date because the enrollment is effective at a date described in paragraph (a)(7) of this section (even though this date is also a regular enrollment date under the plan).

(Approved by the Office of Management and Budget under control number 1210-0101)

[62 FR 16941, Apr. 8, 1997; 62 FR 31693, June 10, 1997, as amended at 62 FR 35905, July 2, 1997]

**§ 2590.701-7 HMO affiliation period as alternative to preexisting condition exclusion.**

(a) *In general.* A group health plan offering health insurance coverage through an HMO, or an HMO that offers health insurance coverage in connection with a group health plan, may impose an affiliation period only if each of the requirements in paragraph (b) of this section is satisfied.

(b) *Requirements for affiliation period.*

(1) No preexisting condition exclusion is imposed with respect to any coverage offered by the HMO in connection with the particular group health plan.

(2) No premium is charged to a participant or beneficiary for the affiliation period.

(3) The affiliation period for the HMO coverage is applied uniformly without regard to any health status-related factors.

(4) The affiliation period does not exceed 2 months (or 3 months in the case of a late enrollee).

(5) The affiliation period begins on the enrollment date.

(6) The affiliation period for enrollment in the HMO under a plan runs concurrently with any waiting period.

(c) *Alternatives to affiliation period.* An HMO may use alternative methods in lieu of an affiliation period to address adverse selection, as approved by the State insurance commissioner or other official designated to regulate HMOs. Nothing in the part requires a State to receive proposals for or approve alternatives to affiliation periods.

**§ 2590.702 Prohibiting discrimination against participants and beneficiaries based on a health status-related factor.**

(a) *In eligibility to enroll—*(1) *In general.* Subject to paragraph (a)(2) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual.

(i) Health status.

(ii) Medical condition (including both physical and mental illnesses), as defined in § 2590.701-2.

(iii) Claims experience.

(iv) Receipt of health care.

(v) Medical history.

(vi) Genetic information, as defined in § 2590.701-2.

(vii) Evidence of insurability (including conditions arising out of acts of domestic violence).

(viii) Disability.

(2) *No application to benefits or exclusions.* To the extent consistent with section 701 of the Act and § 2590.701-3, paragraph (a)(1) of this section shall not be construed—

(i) To require a group health plan, or a health insurance issuer offering group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage; or

(ii) To prevent such a plan or issuer from establishing limitation or restrictions on the amount, level, extent, or nature of the benefits or coverage for

similarly situated individuals enrolled in the plan or coverage.

(3) *Construction.* For purposes of paragraph (a)(1) of this section, rules for eligibility to enroll include rule defining any applicable waiting (or affiliation) periods for such enrollment and rules relating to late and special enrollment.

(4) *Example.* The following example illustrates the rules of this paragraph (a):

*Example.* (i) An employer sponsors a group health plan that is available to all employees who enroll within the first 30 days of their employment. However, individuals who do not enroll in the first 30 days cannot enroll later unless they pass a physical examination.

(ii) In this *Example*, the plan discriminates on the basis of one or more health status-related factors.

(b) *In premiums or contributions—(1) In general.* A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require an individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan based on any health status-related factor, in relation to the individual or a dependent of the individual.

(2) *Construction.* Nothing in paragraph (b)(1) of this section shall be construed—

(i) To restrict the amount that an employer may be charged by an issuer for coverage under a group health plan; or

(ii) To prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to a bona fide wellness program. For purposes of this section, a bona fide wellness program is a program of health promotion and disease prevention.

(3) *Example.* The rules of this paragraph (b) are illustrated by the following example:

*Example.* (i) Plan X offers a premium discount to participants who adhere to a cholesterol-reduction wellness program. Enrollees

are expected to keep a diary of their food intake over 6 weeks. They periodically submit the diary to the plan physician who responds with suggested diet modifications. Enrollees are to modify their diets in accordance with the physician's recommendations. At the end of the 6 weeks, enrollees are given a cholesterol test and those who achieve a count under 200 receive a premium discount.

(ii) In this *Example*, because enrollees who otherwise comply with the program may be unable to achieve a cholesterol count under 200 due to a health status-related factor, this is not a bona fide wellness program and such discounts would discriminate impermissibly based on one or more health status-related factors. However, if, instead, individuals covered by the plan were entitled to receive the discount for complying with the diary and dietary requirements and were not required to pass a cholesterol test, the program would be a bona fide wellness program.

**§ 2590.703 Guaranteed renewability in multiemployer plans and multiple employer welfare arrangements.  
[Reserved]**

**Subpart B—Other Requirements**

**§ 2590.711 Standards relating to benefits for mothers and newborns.**

(a) *Hospital length of stay—(1) General rule.* Except as provided in paragraph (a)(5) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, that provides benefits for a hospital length of stay in connection with childbirth for a mother or her newborn may not restrict benefits for the stay to less than—

(i) 48 hours following a vaginal delivery; or

(ii) 96 hours following a delivery by cesarean section.

(2) *When stay begins—(i) Delivery in a hospital.* If delivery occurs in a hospital, the hospital length of stay for the mother or newborn child begins at the time of delivery (or in the case of multiple births, at the time of the last delivery).

(ii) *Delivery outside a hospital.* If delivery occurs outside a hospital, the hospital length of stay begins at the time the mother or newborn is admitted as a hospital inpatient in connection with childbirth. The determination of whether an admission is in connection

with childbirth is a medical decision to be made by the attending provider.

(3) *Examples.* The rules of paragraphs (a)(1) and (2) of this section are illustrated by the following examples. In each example, the group health plan provides benefits for hospital lengths of stay in connection with childbirth and is subject to the requirements of this section, as follows:

*Example 1.* (i) A pregnant woman covered under a group health plan goes into labor and is admitted to the hospital at 10 p.m. on June 11. She gives birth by vaginal delivery at 6 a.m. on June 12.

(ii) In this *Example 1*, the 48-hour period described in paragraph (a)(1)(i) of this section ends at 6 a.m. on June 14.

*Example 2.* (i) A woman covered under a group health plan gives birth at home by vaginal delivery. After the delivery, the woman begins bleeding excessively in connection with the childbirth and is admitted to the hospital for treatment of the excessive bleeding at 7 p.m. on October 1.

(ii) In this *Example 2*, the 48-hour period described in paragraph (a)(1)(i) of this section ends at 7 p.m. on October 3.

*Example 3.* (i) A woman covered under a group health plan gives birth by vaginal delivery at home. The child later develops pneumonia and is admitted to the hospital. The attending provider determines that the admission is not in connection with childbirth.

(ii) In this *Example 3*, the hospital length-of-stay requirements of this section do not apply to the child's admission to the hospital because the admission is not in connection with childbirth.

(4) *Authorization not required*—(i) *In general.* A plan or issuer may not require that a physician or other health care provider obtain authorization from the plan or issuer for prescribing the hospital length of stay required under paragraph (a)(1) of this section. (See also paragraphs (b)(2) and (c)(3) of this section for rules and examples regarding other authorization and certain notice requirements.)

(ii) *Example.* The rule of this paragraph (a)(4) is illustrated by the following example:

*Example.*

(i) In the case of a delivery by caesarean section, a group health plan subject to the requirements of this section automatically provides benefits for any hospital length of stay of up to 72 hours. For any longer stay, the plan requires an attending provider to complete a certificate of medical necessity.

The plan then makes a determination, based on the certificate of medical necessity, whether a longer stay is medically necessary.

(ii) In this *Example*, the requirement that an attending provider complete a certificate of medical necessity to obtain authorization for the period between 72 hours and 96 hours following a delivery by caesarean section is prohibited by this paragraph (a)(4).

(5) *Exceptions*—(i) *Discharge of mother.* If a decision to discharge a mother earlier than the period specified in paragraph (a)(1) of this section is made by an attending provider, in consultation with the mother, the requirements of paragraph (a)(1) of this section do not apply for any period after the discharge.

(ii) *Discharge of newborn.* If a decision to discharge a newborn child earlier than the period specified in paragraph (a)(1) of this section is made by an attending provider, in consultation with the mother (or the newborn's authorized representative), the requirements of paragraph (a)(1) of this section do not apply for any period after the discharge.

(iii) *Attending provider defined.* For purposes of this section, *attending provider* means an individual who is licensed under applicable State law to provide maternity or pediatric care and who is directly responsible for providing maternity or pediatric care to a mother or newborn child.

(iv) *Example.* The rules of this paragraph (a)(5) are illustrated by the following example:

*Example.* (i) A pregnant woman covered under a group health plan subject to the requirements of this section goes into labor and is admitted to a hospital. She gives birth by caesarean section. On the third day after the delivery, the attending provider for the mother consults with the mother, and the attending provider for the newborn consults with the mother regarding the newborn. The attending providers authorize the early discharge of both the mother and the newborn. Both are discharged approximately 72 hours after the delivery. The plan pays for the 72-hour hospital stays.

(ii) In this *Example*, the requirements of this paragraph (a) have been satisfied with respect to the mother and the newborn. If either is readmitted, the hospital stay for the readmission is not subject to this section.

(b) *Prohibitions*—(1) *With respect to mothers*—(i) *In general.* A group health

plan, and a health insurance issuer of offering group health insurance coverage, may not—

(A) Deny a mother or her newborn child eligibility or continued eligibility to enroll or renew coverage under the terms of the plan solely to avoid the requirements of this section; or

(B) Provide payments (including payments-in-kind) or rebates to a mother to encourage her to accept less than the minimum protections available under this section.

(ii) *Examples.* The rules of this paragraph (b)(1) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section, as follows:

*Example 1.* (i) A group health plan provides benefits for at least a 48-hour hospital length of stay following a vaginal delivery. If a mother and newborn covered under the plan are discharged within 24 hours after the delivery, the plan will waive the copayment and deductible.

(ii) In this *Example 1*, because waiver of the copayment and deductible is in the nature of a rebate that the mother would not receive if she and her newborn remained in the hospital, it is prohibited by this paragraph (b)(1). (In addition, the plan violates paragraph (b)(2) of this section because, in effect, no copayment or deductible is required for the first portion of the stay and a double copayment and a deductible are required for the second portion of the stay.)

*Example 2.* (i) A group health plan provides benefits for at least a 48-hour hospital length of stay following a vaginal delivery. In the event that a mother and her newborn are discharged earlier than 48 hours and the discharges occur after consultation with the mother in accordance with the requirements of paragraph (a)(5) of this section, the plan provides for a follow-up visit by a nurse within 48 hours after the discharges to provide certain services that the mother and her newborn would otherwise receive in the hospital.

(ii) In this *Example 2*, because the follow-up visit does not provide any services beyond what the mother and her newborn would receive in the hospital, coverage for the follow-up visit is not prohibited by this paragraph (b)(1).

(2) *With respect to benefit restrictions—*  
(i) *In general.* Subject to paragraph (c)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not restrict the benefits for any portion of a hospital length of stay re-

quired under paragraph (a) of this section in a manner that is less favorable than the benefits provided for any preceding portion of the stay.

(ii) *Example.* The rules of this paragraph (b)(2) are illustrated by the following example:

*Example.* (i) A group health plan subject to the requirements of this section provides benefits for hospital lengths of stay in connection with childbirth. In the case of a delivery by caesarean section, the plan automatically pays for the first 48 hours. With respect to each succeeding 24-hour period, the participant or beneficiary must call the plan to obtain precertification from a utilization reviewer, who determines if an additional 24-hour period is medically necessary. If this approval is not obtained, the plan will not provide benefits for any succeeding 24-hour period.

(ii) In this *Example*, the requirement to obtain precertification for the two 24-hour periods immediately following the initial 48-hour stay is prohibited by this paragraph (b)(2) because benefits for the latter part of the stay are restricted in a manner that is less favorable than benefits for a preceding portion of the stay. (However, this section does not prohibit a plan from requiring precertification for any period after the first 96 hours.) In addition, if the plan's utilization reviewer denied any mother or her newborn benefits within the 96-hour stay, the plan would also violate paragraph (a) of this section.

(3) *With respect to attending providers.* A group health plan, and a health insurance issuer offering group health insurance coverage, may not directly or indirectly—

(i) Penalize (for example, take disciplinary action against or retaliate against), or otherwise reduce or limit the compensation of, an attending provider because the provider furnished care to a participant or beneficiary in accordance with this section; or

(ii) Provide monetary or other incentives to an attending provider to induce the provider to furnish care to a participant or beneficiary in a manner inconsistent with this section, including providing any incentive that could induce an attending provider to discharge a mother or newborn earlier than 48 hours (or 96 hours) after delivery.

(c) *Construction.* With respect to this section, the following rules of construction apply:



(1) *Hospital stays not mandatory.* This section does not require a mother to—

- (i) Give birth in a hospital; or
- (ii) Stay in the hospital for a fixed period of time following the birth of her child.

(2) *Hospital stay benefits not mandated.* This section does not apply to any group health plan, or any group health insurance coverage, that does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

(3) *Cost-sharing rules—(i) In general.* This section does not prevent a group health plan or a health insurance issuer offering group health insurance coverage from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn under the plan or coverage, except that the coinsurance or other cost-sharing for any portion of the hospital length of stay required under paragraph (a) of this section may not be greater than that for any preceding portion of the stay.

(ii) *Examples.* The rules of this paragraph (c)(3) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section, as follows:

*Example 1.* (i) A group health plan provides benefits for at least a 48-hour hospital length of stay in connection with vaginal deliveries. The plan covers 80 percent of the cost of the stay for the first 24-hour period and 50 percent of the cost of the stay for the second 24-hour period. Thus, the coinsurance paid by the patient increases from 20 percent to 50 percent after 24 hours.

(ii) In this *Example 1*, the plan violates the rules of this paragraph (c)(3) because coinsurance for the second 24-hour period of the 48-hour stay is greater than that for the preceding portion of the stay. (In addition, the plan also violates the similar rule in paragraph (b)(2) of this section.)

*Example 2.* (i) A group health plan generally covers 70 percent of the cost of a hospital length of stay in connection with childbirth. However, the plan will cover 80 percent of the cost of the stay if the participant or beneficiary notifies the plan of the pregnancy in advance of admission and uses whatever hospital the plan may designate.

(ii) In this *Example 2*, the plan does not violate the rules of this paragraph (c)(3) because the level of benefits provided (70 percent or 80 percent) is consistent throughout the 48-hour (or 96-hour) hospital length of stay re-

quired under paragraph (a) of this section. (In addition, the plan does not violate the rules in paragraph (a)(4) or (b)(2) of this section.)

(4) *Compensation of attending provider.* This section does not prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating with an attending provider the level and type of compensation for care furnished in accordance with this section (including paragraph (b) of this section).

(d) *Notice requirement.* See 29 CFR 2520.102–3 (u) and (v)(2) (relating to the disclosure requirement under section 711(d) of the Act).

(e) *Applicability in certain States—(1) Health insurance coverage.* The requirements of section 711 of the Act and this section do not apply with respect to health insurance coverage offered in connection with a group health plan if there is a State law regulating the coverage that meets any of the following criteria:

(i) The State law requires the coverage to provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by caesarean section.

(ii) The State law requires the coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or any other established professional medical association.

(iii) The State law requires, in connection with the coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or is required to be made by) the attending provider in consultation with the mother. State laws that require the decision to be made by the attending provider with the consent of the mother satisfy the criterion of this paragraph (e)(1)(iii).

(2) *Group health plans—(i) Fully-insured plans.* For a group health plan that provides benefits solely through health insurance coverage, if the State law regulating the health insurance coverage meets any of the criteria in paragraph (e)(1) of this section, then

the requirements of section 711 of the Act and this section do not apply.

(ii) *Self-insured plans.* For a group health plan that provides all benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage, the requirements of section 711 of the Act and this section apply.

(iii) *Partially-insured plans.* For a group health plan that provides some benefits through health insurance coverage, if the State law regulating the health insurance coverage meets any of the criteria in paragraph (e)(1) of this section, then the requirements of section 711 of the Act and this section apply only to the extent the plan provides benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage.

(3) *Relation to section 731(a) of the Act.* The preemption provisions contained in section 731(a)(1) of the Act and § 2590.731(a) do not supersede a State law described in paragraph (e)(1) of this section.

(4) *Examples.* The rules of this paragraph (e) are illustrated by the following examples:

*Example 1.* (i) A group health plan buys group health insurance coverage in a State that requires that the coverage provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by caesarean section.

(ii) In this *Example 1*, the coverage is subject to State law, and the requirements of section 711 of the Act and this section do not apply.

*Example 2.* (i) A self-insured group health plan covers hospital lengths of stay in connection with childbirth in a State that requires health insurance coverage to provide for maternity care in accordance with guidelines established by the American College of Obstetricians and Gynecologists and to provide for pediatric care in accordance with guidelines established by the American Academy of Pediatrics.

(ii) In this *Example 2*, even though the State law satisfies the criterion of paragraph (e)(1)(ii) of this section, because the plan provides benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage, the plan is subject to the requirements of section 711 of the Act and this section.

(f) *Effective date.* Section 711 of the Act applies to group health plans, and

health insurance issuers offering group health insurance coverage, for plan years beginning on or after January 1, 1998. This section applies to group health plans, and health insurance issuers offering group health insurance coverage, for plan years beginning on or after January 1, 1999.

[63 FR 57556, Oct. 27, 1998]

**§ 2590.712 Parity in the application of certain limits to mental health benefits.**

(a) *Definitions.* For purposes of this section, except where the context clearly indicates otherwise, the following definitions apply:

*Aggregate lifetime limit* means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan (or group health insurance coverage offered in connection with such a plan) for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

*Annual limit* means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a plan (or group health insurance coverage offered in connection with such a plan) for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

*Medical/surgical benefits* means benefits for medical or surgical services, as defined under the terms of the plan or group health insurance coverage, but does not include mental health benefits.

*Mental health benefits* means benefits for mental health services, as defined under the terms of the plan or group health insurance coverage, but does not include benefits for treatment of substance abuse or chemical dependency.

(b) *Requirements regarding limits on benefits—(1)—general—(i) General parity requirement.* A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health benefits must comply with paragraph (b)(2), (3), or (6) of this section.

(ii) *Exception.* The rule in paragraph (b)(1)(i) of this section does not apply if a plan, or coverage, satisfies the requirements of paragraph (e) or (f) of this section.

(2) *Plan with no limit or limits on less than one-third of all medical/surgical benefits.* If a plan (or group health insurance coverage) does not include an aggregate lifetime or annual limit on any medical/surgical benefits or includes aggregate lifetime or annual limits that apply to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual limit, respectively, on mental health benefits.

(3) *Plan with a limit on at least two-thirds of all medical/surgical benefits.* If a plan (or group health insurance coverage) includes an aggregate lifetime or annual limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health benefits in a manner that does not distinguish between the medical/surgical and mental health benefits; or

(ii) Not include an aggregate lifetime or annual limit on mental health benefits that is less than the aggregate lifetime or annual limit, respectively, on the medical/surgical benefits.

(4) *Examples.* The rules of paragraphs (b)(2) and (3) of this section are illustrated by the following examples:

*Example 1.* (i) Prior to the effective date of the mental health parity provisions, a group health plan had no annual limit on medical/surgical benefits and had a \$10,000 annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Eliminating the plan's annual limit on mental health benefits;

(B) Replacing the plan's previous annual limit on mental health benefits with a \$500,000 annual limit on all benefits (including medical/surgical and mental health benefits); and

(C) Replacing the plan's previous annual limit on mental health benefits with a \$250,000 annual limit on medical/surgical benefits and a \$250,000 annual limit on mental health benefits.

(ii) In this *Example 1*, each of the three options being considered by the plan sponsor

would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

*Example 2.* (i) Prior to the effective date of the mental health parity provisions, a group health plan had a \$100,000 annual limit on medical/surgical inpatient benefits, a \$50,000 annual limit on medical/surgical outpatient benefits, and a \$100,000 annual limit on all mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Replacing the plan's previous annual limit on mental health benefits with a \$150,000 annual limit on mental health benefits; and

(B) Replacing the plan's previous annual limit on mental health benefits with a \$100,000 annual limit on mental health inpatient benefits and a \$50,000 annual limit on mental health outpatient benefits.

(ii) In this *Example 2*, each option under consideration by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

*Example 3.* (i) A group health plan that is subject to the requirements of this section has no aggregate lifetime or annual limit for either medical/surgical benefits or mental health benefits. While the plan provides medical/surgical benefits with respect to both network and out-of-network providers, it does not provide mental health benefits with respect to out-of-network providers.

(ii) In this *Example 3*, the plan complies with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

*Example 4.* (i) Prior to the effective date of the mental health parity provisions, a group health plan had an annual limit on medical/surgical benefits and a separate but identical annual limit on mental health benefits. The plan included benefits for treatment of substance abuse and chemical dependency in its definition of mental health benefits. Accordingly, claims paid for treatment of substance abuse and chemical dependency were counted in applying the annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Making no change in the plan so that claims paid for treatment of substance abuse and chemical dependency continue to count in applying the annual limit on mental health benefits;

(B) Amending the plan to count claims paid for treatment of substance abuse and chemical dependency in applying the annual limit on medical/surgical benefits (rather

than counting those claims in applying the annual limit on mental health benefits);

(C) Amending the plan to provide a new category of benefits for treatment of chemical dependency and substance abuse that is subject to a separate, lower limit and under which claims paid for treatment of substance abuse and chemical dependency are counted only in applying the annual limit on this separate category; and

(D) Amending the plan to eliminate distinctions between medical/surgical benefits and mental health benefits and establishing an overall limit on benefits offered under the plan under which claims paid for treatment of substance abuse and chemical dependency are counted with medical/surgical benefits and mental health benefits in applying the overall limit.

(ii) In this *Example 4*, the group health plan is described in paragraph (b)(3) of this section. Because mental health benefits are defined in paragraph (a) of this section as excluding benefits for treatment of substance abuse and chemical dependency, the inclusion of benefits for treatment of substance abuse and chemical dependency in applying an aggregate lifetime limit or annual limit on mental health benefits under option (A) of this *Example 4* would not comply with the requirements of paragraph (b)(3) of this section. However, options (B), (C), and (D) of this *Example 4* would comply with the requirements of paragraph (b)(3) of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

(5) *Determining one-third and two-thirds of all medical/surgical benefits.* For purposes of this paragraph (b), the determination of whether the portion of medical/surgical benefits subject to a limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual limits). Any reasonable method may be used to determine whether the dollar amounts expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

(6) *Plan not described in paragraph (b)(2) or (3) of this section—(i) In general.* A group health plan (or group health insurance coverage) that is not de-

scribed in paragraph (b)(2) or (3) of this section, must either—

(A) Impose no aggregate lifetime or annual limit, as appropriate, on mental health benefits; or

(B) Impose an aggregate lifetime or annual limit on mental health benefits that is no less than an average limit calculated for medical/surgical benefits in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(6)(i)(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

(ii) *Weighting.* For purposes of this paragraph (b)(6), the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (b)(5) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(iii) *Example.* The rules of this paragraph (b)(6) are illustrated by the following example:

*Example.* (i) A group health plan that is subject to the requirements of this section includes a \$100,000 annual limit on medical/surgical benefits related to cardio-pulmonary diseases. The plan does not include an annual limit on any other category of medical/surgical benefits. The plan determines that 40% of the dollar amount of plan payments for medical/surgical benefits are related to cardio-pulmonary diseases. The plan determines that \$1,000,000 is a reasonable estimate of the upper limit on the dollar amount that the plan may incur with respect to the other 60% of payments for medical/surgical benefits.

(ii) In this *Example*, the plan is not described in paragraph (b)(3) of this section because there is not one annual limit that applies to at least two-thirds of all medical/surgical benefits. Further, the plan is not described in paragraph (b)(2) of this section because more than one-third of all medical/surgical benefits are subject to an annual limit. Under this paragraph (b)(6), the plan sponsor can choose either to include no annual limit on mental health benefits, or to include an annual limit on mental health benefits that is not less than the weighted average of the annual limits applicable to each category of medical/surgical benefits. In this example, the minimum weighted average annual limit that can be applied to mental health benefits is \$640,000 ( $40\% \times \$100,000 + 60\% \times \$1,000,000 = \$640,000$ ).

(c) *Rule in the case of separate benefit packages.* If a group health plan offers two or more benefit packages, the requirements of this section, including the exemption provisions in paragraph (f) of this section, apply separately to each benefit package. Examples of a group health plan that offers two or more benefit packages include a group health plan that offers employees a choice between indemnity coverage or HMO coverage, and a group health plan that provides one benefit package for retirees and a different benefit package for current employees.

(d) *Applicability—(1) Group health plans.* The requirements of this section apply to a group health plan offering both medical/surgical benefits and mental health benefits regardless of whether the mental health benefits are administered separately under the plan.

(2) *Health insurance issuers.* The requirements of this section apply to a health insurance issuer offering health insurance coverage for both medical/surgical benefits and mental health benefits in connection with a group health plan.

(3) *Scope.* This section does not—

(i) Require a group health plan (or health insurance issuer offering coverage in connection with a group health plan) to provide any mental health benefits; or

(ii) Affect the terms and conditions (including cost sharing, limits on the number of visits or days of coverage, requirements relating to medical necessity, requiring prior authorization for treatment, or requiring primary

care physicians' referrals for treatment) relating to the amount, duration, or scope of the mental health benefits under the plan (or coverage) except as specifically provided in paragraph (b) of this section.

(e) *Small employer exemption—(1) In general.* The requirements of this section do not apply to a group health plan (or health insurance issuer offering coverage in connection with a group health plan) for a plan year of a small employer. For purposes of this paragraph (e), the term *small employer* means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. See section 732(a) of the Act and § 2590.732(a), which provide that this section (and certain other sections) does not apply to any group health plan (and health insurance issuer offering coverage in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) *Rules in determining employer size.* For purposes of paragraph (e)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. 414) are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(f) *Increased cost exemption—(1) In general.* A group health plan (or health insurance coverage offered in connection with a group health plan) is not subject to the requirements of this section if the requirements of this paragraph (f) are satisfied. If a plan offers more than

one benefit package, this paragraph (f) applies separately to each benefit package. Except as provided in paragraph (h) of this section, a plan must comply with the requirements of paragraph (b)(1)(i) of this section for the first plan year beginning on or after January 1, 1998, and must continue to comply with the requirements of paragraph (b)(1)(i) of this section until the plan satisfies the requirements in this paragraph (f). In no event is the exemption of this paragraph (f) effective until 30 days after the notice requirements in paragraph (f)(3) of this section are satisfied. If the requirements of this paragraph (f) are satisfied with respect to a plan, the exemption continues in effect (at the plan's discretion) until September 30, 2001, even if the plan subsequently purchases a different policy from the same or a different issuer and regardless of any other changes to the plan's benefit structure.

(2) *Calculation of the one-percent increase*—(i) *Ratio*. A group health plan (or group health insurance coverage) satisfies the requirements of this para-

graph (f)(2) if the application of paragraph (b)(1)(i) of this section to the plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least one percent. The application of paragraph (b)(1)(i) of this section results in an increased cost of at least one percent under a group health plan (or for such coverage) only if the ratio below equals or exceeds 1.01000. The ratio is determined as follows:

(A) The incurred expenditures during the base period, divided by,

(B) The incurred expenditures during the base period, reduced by—

(1) The claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section; and

(2) Administrative expenses attributable to complying with the requirements of this section.

(ii) *Formula*. The ratio of paragraph (f)(2)(i) of this section is expressed mathematically as follows:

$$\frac{IE}{IE - (CE + AE)} \geq 1.01000$$

(A) *IE* means the incurred expenditures during the base period.

(B) *CE* means the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section

(C) *AE* means administrative costs related to claims in *CE* and other administrative costs attributable to complying with the requirements of this section.

(iii) *Incurred expenditures*. *Incurred expenditures* means actual claims incurred during the base period and reported within two months following the base period, and administrative costs for all benefits under the group health plan, including mental health benefits and medical/surgical benefits, during the base period. Incurred expenditures do not include premiums.

(iv) *Base period*. *Base period* means the period used to calculate whether

the plan may claim the one-percent increased cost exemption in this paragraph (f). The base period must begin on the first day in any plan year that the plan complies with the requirements of paragraph (b)(1)(i) of this section and must extend for a period of at least six consecutive calendar months. However, in no event may the base period begin prior to September 26, 1996 (the date of enactment of the Mental Health Parity Act (Pub. L. 104-204, 110 Stat. 2944)).

(v) *Rating pools*. For plans that are combined in a pool for rating purposes, the calculation under this paragraph (f)(2) for each plan in the pool for the base period is based on the incurred expenditures of the pool, whether or not all the plans in the pool have participated in the pool for the entire base period. (However, only the plans that have complied with paragraph (b)(1)(i) of this section for at least six months

as a member of the pool satisfy the requirements of this paragraph (f)(2).) Otherwise, the calculation under this paragraph (f)(2) for each plan is calculated by the plan administrator (or issuer) based on the incurred expenditures of the plan.

(vi) *Examples.* The rules of this paragraph (f)(2) are illustrated by the following examples:

*Example 1.* (i) A group health plan has a plan year that is the calendar year. The plan satisfies the requirements of paragraph (b)(1)(i) of this section as of January 1, 1998. On September 15, 1998, the plan determines that \$1,000,000 in claims have been incurred during the period between January 1, 1998 and June 30, 1998 and reported by August 30, 1998. The plan also determines that \$100,000 in administrative costs have been incurred for all benefits under the group health plan, including mental health benefits. Thus, the plan determines that its incurred expenditures for the base period are \$1,100,000. The plan also determines that the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section are \$40,000 and that administrative expenses attributable to complying with the requirements of this section are \$10,000. Thus, the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are \$1,050,000 ( $\$1,100,000 - (\$40,000 + \$10,000) = \$1,050,000$ ).

(ii) In this *Example 1*, the plan satisfies the requirements of this paragraph (f)(2) because the application of this section results in an increased cost of at least one percent under the terms of the plan ( $\$1,050,000/\$1,050,000 = 1.04762$ ).

*Example 2.* (i) A health insurance issuer sells a group health insurance policy that is rated on a pooled basis and is sold to 30 group health plans. One of the group health plans inquires whether it qualifies for the one-percent increased cost exemption. The issuer performs the calculation for the pool as a whole and determines that the application of this section results in an increased cost of 0.500 percent (for a ratio under this paragraph (f)(2) of 1.00500) for the pool. The issuer informs the requesting plan and the other plans in the pool of the calculation.

(ii) In this *Example 2*, none of the plans satisfy the requirements of this paragraph (f)(2) and a plan that purchases a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section. In addition, an issuer that issues to any of the plans in the pool a policy not complying with the requirements

of paragraph (b)(1)(i) of this section violates the requirements of this section.

*Example 3.* (i) A partially insured plan is collecting the information to determine whether it qualifies for the exemption. The plan administrator determines the incurred expenses for the base period for the self-funded portion of the plan to be \$2,000,000 and the administrative expenses for the base period for the self-funded portion to be \$200,000. For the insured portion of the plan, the plan administrator requests data from the insurer. For the insured portion of the plan, the plan's own incurred expenses for the base period are \$1,000,000 and the administrative expenses for the base period are \$100,000. The plan administrator determines that under the self-funded portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are \$0 because the self-funded portion does not cover mental health benefits and the plan's administrative costs attributable to complying with the requirements of this section are \$1,000. The issuer determines that under the insured portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are \$25,000 and the administrative costs attributable to complying with the requirements of this section are \$1,000. Thus, the total incurred expenditures for the plan for the base period are \$3,300,000 ( $\$2,000,000 + \$200,000 + \$1,000,000 + \$100,000 = \$3,300,000$ ) and the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are \$3,273,000 ( $\$3,300,000 - (\$0 + \$1,000 + \$25,000 + \$1,000) = \$3,273,000$ ).

(ii) In this *Example 3*, the plan does not satisfy the requirements of this paragraph (f)(2) because the application of this section does not result in an increased cost of at least one percent under the terms of the plan ( $\$3,300,000/\$3,273,000 = 1.00825$ ).

(3) *Notice of exemption—(i) Participants and beneficiaries—(A) In general.* A group health plan must notify participants and beneficiaries of the plan's decision to claim the one-percent increased cost exemption. The notice must include the following information:

(1) A statement that the plan is exempt from the requirements of this section and a description of the basis for the exemption;

(2) The name and telephone number of the individual to contact for further information;

(3) The plan name and plan number (PN);

(4) The plan administrator's name, address, and telephone number;

(5) For single-employer plans, the plan sponsor's name, address, and telephone number (if different from paragraph (f)(3)(i)(A)(3) of this section) and the plan sponsor's employer identification number (EIN);

(6) The effective date of the exemption;

(7) The ability of participants and beneficiaries to contact the plan administrator to see how benefits may be affected as a result of the plan's claim of the exemption; and

(8) The availability, upon request and free of charge, of a summary of the information required under paragraph (f)(4) of this section.

(B) *Use of summary of material reductions in covered services or benefits.* A plan may satisfy the requirements of paragraph (f)(3)(i)(A) of this section by providing participants and beneficiaries (in accordance with paragraph (f)(3)(i)(C) of this section) with a summary of material reductions in covered services or benefits required under § 2520.104b-3(d) that also includes the information of this paragraph (f)(3)(i). However, in all cases, the exemption is not effective until 30 days after notice has been sent.

(C) *Delivery.* The notice described in this paragraph (f)(3)(i) is required to be provided to all participants and beneficiaries. The notice may be furnished by any method of delivery that satisfies the requirements of section 104(b)(1) of ERISA (e.g., first-class mail). If the notice is provided to the participant at the participant's last known address, then the requirements of this paragraph (f)(3)(i) are satisfied with respect to the participant and all beneficiaries residing at that address. If a beneficiary's last known address is different from the participant's last known address, a separate notice is required to be provided to the beneficiary at the beneficiary's last known address.

(D) *Example.* The rules of this paragraph (f)(3)(i) are illustrated by the following example:

*Example.* (i) A group health plan has a plan year that is the calendar year and has an open enrollment period every November 1 through November 30. The plan determines

on September 15 that it satisfies the requirements of paragraph (f)(2) of this section. As part of its open enrollment materials, the plan mails, on October 15, to all participants and beneficiaries a notice satisfying the requirements of this paragraph (f)(3)(i).

(ii) In this *Example*, the plan has sent the notice in a manner that complies with this paragraph (f)(3)(i).

(ii) *Federal agencies—(A) Church plans.* A church plan (as defined in section 414(e) of the Internal Revenue Code) claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of the Treasury. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(B) *Group health plans subject to Part 7 of Subtitle B of Title I of ERISA.* A group health plan subject to Part 7 of Subtitle B of Title I of ERISA, and claiming the exemption of this paragraph (f) for any benefit package, must provide notice to the Department of Labor. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(C) *Nonfederal governmental plans.* A group health plan that is a nonfederal governmental plan claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of Health and Human Services (HHS). This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(4) *Availability of documentation.* The plan (or issuer) must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based. An individual who is not a participant or beneficiary and who presents a notice



described in paragraph (f)(3)(i) of this section is considered to be a representative. A representative may request the summary of information by providing the plan a copy of the notice provided to the participant under paragraph (f)(3)(i) of this section with any individually identifiable information redacted. The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with paragraph (b)(1)(i) of this section, the administrative costs related to those claims, and other administrative costs attributable to complying with the requirements of this section. In no event should the summary of information include any individually identifiable information.

(g) *Special rules for group health insurance coverage—(1) Sale of nonparity policies.* An issuer may sell a policy without parity (as described in paragraph (b) of this section) only to a plan that meets the requirements of paragraphs (e) or (f) of this section.

(2) *Duration of exemption.* After a plan meets the requirements of paragraph (f) of this section, the plan may change issuers without having to meet the requirements of paragraph (f) of this section again before September 30, 2001.

(h) *Effective dates—(1) In general.* The requirements of this section are applicable for plan years beginning on or after January 1, 1998.

(2) *Limitation on actions.* (i) Except as provided in paragraph (h)(3) of this section, no enforcement action is to be taken by the Secretary against a group health plan that has sought to comply in good faith with the requirements of section 712 of the Act, with respect to a violation that occurs before the earlier of—

(A) The first day of the first plan year beginning on or after April 1, 1998; or

(B) January 1, 1999.

(ii) Compliance with the requirements of this section is deemed to be good faith compliance with the requirements of section 712 of Part 7 of Subtitle B of Title I of ERISA.

(iii) The rules of this paragraph (h)(2) are illustrated by the following examples:

*Example 1.* (i) A group health plan has a plan year that is the calendar year. The plan complies with section 712 of Part 7 of Subtitle B of Title I of ERISA in good faith using assumptions inconsistent with paragraph (b)(6) of this section relating to weighted averages for categories of benefits.

(ii) In this *Example 1*, no enforcement action may be taken against the plan with respect to a violation resulting solely from those assumptions and occurring before January 1, 1999.

*Example 2.* (i) A group health plan has a plan year that is the calendar year. For the entire 1998 plan year, the plan applies a \$1,000,000 annual limit on medical/surgical benefits and a \$100,000 annual limit on mental health benefits.

(ii) In this *Example 2*, the plan has not sought to comply with the requirements of section 712 of the Act in good faith and this paragraph (h)(2) does not apply.

(3) *Transition period for increased cost exemption—(i) In general.* No enforcement action will be taken against a group health plan that is subject to the requirements of this section based on a violation of this section that occurs before April 1, 1998 solely because the plan claims the increased cost exemption under section 712(c)(2) of Part 7 of Subtitle B of Title I of ERISA based on assumptions inconsistent with the rules under paragraph (f) of this section, provided that a plan amendment that complies with the requirements of paragraph (b)(1)(i) of this section is adopted and effective no later than March 31, 1998 and the plan complies with the notice requirements in paragraph (h)(3)(ii) of this section.

(ii) *Notice of plan's use of transition period.* (A) A group health plan satisfies the requirements of this paragraph (h)(3)(ii) only if the plan provides notice to the applicable federal agency and posts such notice at the location(s) where documents must be made available for examination by participants and beneficiaries under section 104(b)(2) of ERISA and the regulations thereunder (29 CFR 2520.104b-1(b)(3)). The notice must indicate the plan's decision to use the transition period in paragraph (h)(3)(i) of this section by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event later than March 31, 1998.

For a group health plan that is a church plan, the applicable federal agency is the Department of the Treasury. For a group health plan that is subject to Part 7 of Subtitle B of Title I of ERISA, the applicable federal agency is the Department of Labor. For a group health plan that is a non-federal governmental plan, the applicable federal agency is the Department of Health and Human Services. The notice must include—

(1) The name of the plan and the plan number (PN);

(2) The name, address, and telephone number of the plan administrator;

(3) For single-employer plans, the name, address, and telephone number of the plan sponsor (if different from the plan administrator) and the plan sponsor's employer identification number (EIN);

(4) The name and telephone number of the individual to contact for further information; and

(5) The signature of the plan administrator and the date of the signature.

(B) The notice must be provided at no charge to participants or their representative within 15 days after receipt of a written or oral request for such notification, but in no event before the notice has been sent to the applicable federal agency.

(i) *Sunset.* This section does not apply to benefits for services furnished on or after September 30, 2001.

[62 FR 66957, Dec. 22, 1997]

### Subpart C—General Provisions

#### **§ 2590.731 Preemption; State flexibility; construction.**

(a) *Continued applicability of State law with respect to health insurance issuers.* Subject to paragraph (b) of this section and except as provided in paragraph (c) of this section, part 7 of subtitle B of title I of the Act is not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirements of this part.

(b) *Continued preemption with respect to group health plans.* Nothing in part 7 of subtitle B of title I of the Act affects or modifies the provisions of section 514 of the Act with respect to group health plans.

(c) *Special rules—*(1) *In general.* Subject to paragraph (c)(2) of this section, the provisions of part 7 of subtitle B of title I of the Act relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 701 which differs from the standards or requirements specified in such section.

(2) *Exceptions.* Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

(i) Shortens the period of time from the "6-month period" described in section 701(a)(1) of the Act and § 2590.701-3(a)(1)(i) (for purposes of identifying a preexisting condition);

(ii) Shortens the period of time from the "12 months" and "18 months" described in section 701(a)(2) of the Act and § 2590.701-3(a)(1)(ii) (for purposes of applying a preexisting condition exclusion period);

(iii) Provides for a greater number of days than the "63 day period" described in sections 701(c)(2)(A) and (d)(4)(A) of the Act and §§ 2590.701-3(a)(1)(iii) and 2590.701-4 (for purposes of applying the break in coverage rules);

(iv) Provides for a greater number of days than the "30-day period" described in sections 701 (b)(2) and (d)(1) of the Act and § 2590.701-3(b) (for purposes of the enrollment periods and preexisting condition exclusion periods for certain newborns and children that are adopted or placed for adoption);

(v) Prohibits the imposition of any preexisting condition exclusion in cases not described in section 701(d) of the Act or expands the exceptions described therein;

(vi) Requires special enrollment periods in addition to those required under section 701(f) of the Act; or

(vii) Reduces the maximum period permitted in an affiliation period under section 701(g)(1)(B) of the Act.

(d) *Definitions*—(1) *State law*. For purposes of this section the term *State law* includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia is treated as a State law rather than a law of the United States.

(2) *State*. For purposes of this section the term *State* includes a State, the Northern Mariana Islands, any political subdivisions of a State or such Island, or any agency or instrumentality of either.

[62 FR 16941, Apr. 8, 1997; 62 FR 31670, 31693, June 10, 1997]

**§ 2590.732 Special rules relating to group health plans.**

(a) *General exception for certain small group health plans*. The requirements of this part 7 of subtitle B of title I of the Act do not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than 2 participants who are current employees.

(b) *Excepted benefits*—(1) *In general*. The requirements of subparts A and C of this part do not apply to any group health plan (or any group health insurance coverage offered in connection with a group health plan) in relation to its provision of the benefits described in paragraph (b)(2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances*. The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar insurance;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—(i) *In general*. Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan, as defined in paragraph (b)(3)(ii) of this section.

(ii) *Integral*. For purposes of paragraph (b)(3)(i) of this section, benefits are deemed to be an integral part of a plan unless a participant has the right to elect not to receive coverage for the benefits and, if the participant elects to receive coverage for the benefits, the participant pays an additional premium or contribution for that coverage.

(iii) *Limited scope*. Limited scope dental or vision benefits are dental or vision benefits that are sold under a separate policy or rider and that are limited in scope to a narrow range or type of benefits that are generally excluded from hospital/medical/surgical benefit packages.

(iv) *Long-term care*. Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care insurance services, as defined in section 7702B(c)(1) of the Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b) of the Internal Revenue Code; or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated*. Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed dollar indemnity insurance (for example, \$100/day) is excepted only if it meets each of the conditions specified in paragraph (b)(4)(ii) of this section.

(ii) *Conditions.* Benefits are described in paragraph (b)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

(5) *Supplemental benefits.* The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance:

(i) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(ii) Coverage supplemental to the coverage provided under chapter 55, title 10 of the United States Code (also known as CHAMPUS supplemental programs); and

(iii) Similar supplemental coverage provided to coverage under a group health plan.

(c) *Treatment of partnerships.* [Reserved]

[62 FR 16941, Apr. 8, 1997; 62 FR 31670, June 10, 1997]

#### § 2590.734 Enforcement. [Reserved]

#### § 2590.736 Effective dates.

(a) *General effective dates—(1) Non-collectively-bargained plans.* Except as otherwise provided in this section, part 7 of subtitle B of title I of the Act and subparts A and C of this part apply with respect to group health plans, including health insurance issuers offering health insurance coverage in connection with group health plans, for plan years beginning after June 30, 1997.

(2) *Collectively bargained plans.* Except as otherwise provided in this section (other than paragraph (a)(1) of this section), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements be-

tween employee representatives and one or more employers ratified before August 21, 1996, part 7 of subtitle B of title I of the Act and subparts A and C of this part do not apply to plan years beginning before the later of July 1, 1997, or the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after August 21, 1996). For these purposes, any plan amendment made pursuant to a collective bargaining agreement relating to the plan, that amends the plan solely to conform to any requirement of such part, is not treated as a termination of the collective bargaining agreement.

(3)(i) *Preexisting condition exclusion periods for current employees.* Any preexisting condition exclusion period permitted under § 2590.701-3 is measured from the individual's enrollment date in the plan. Such exclusion period, as limited under § 2590.701-3, may be completed prior to the effective date of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for his or her plan. Therefore, on the date the individual's plan becomes subject to part 7 of subtitle B of title I of the Act, no preexisting condition exclusion may be imposed with respect to an individual beyond the limitation of § 2590.701-3. For an individual who has not completed the permitted exclusion period under HIPAA, upon the effective date for his or her plan, the individual may use creditable coverage that the individual had prior to the enrollment date to reduce the remaining preexisting condition exclusion period applicable to the individual.

(ii) *Examples.* The following examples illustrate the rules of this paragraph (a)(3):

*Example 1.* (i) Individual A has been working for Employer X and has been covered under Employer X's plan since March 1, 1997. Under Employer X's plan, as in effect before January 1, 1998, there is no coverage for any preexisting condition. Employer X's plan year begins on January 1, 1998. A's enrollment date in the plan is March 1, 1997 and A has no creditable coverage before this date.

(ii) In this *Example 1*, Employer X may continue to impose the preexisting condition exclusion under the plan through February 28, 1998 (the end of the 12-month period using anniversary dates).

*Example 2.* (i) Same facts as in *Example 1*, except that A's enrollment date was August 1, 1996, instead of March 1, 1997.

(ii) In this *Example 2*, on January 1, 1998, Employer X's plan may no longer exclude treatment for any preexisting condition that A may have; however, because Employer X's plan is not subject to HIPAA until January 1, 1998, A is not entitled to claim reimbursement for expenses under the plan for treatments for any preexisting condition of A received before January 1, 1998.

(b) *Effective date for certification requirement*—(1) *In general.* Subject to the transitional rule in § 2590.701-5(a)(5)(iii), the certification rules of § 2590.701-5 apply to events occurring on or after July 1, 1996.

(2) *Period covered by certificate.* A certificate is not required to reflect coverage before July 1, 1996.

(3) *No certificate before June 1, 1997.* Notwithstanding any other provision of subpart A or C of this part, in no case is a certificate required to be provided before June 1, 1997.

(c) *Limitation on actions.* No enforcement action is to be taken, pursuant to part 7 of subtitle B of title I of the Act, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by part 7 of subtitle B of title I of the Act before January 1, 1998, if the plan or issuer has sought to comply in good faith with such requirements. Compliance with this part is deemed to be good faith compliance with the requirements of part 7 of subtitle B of title I of the Act.

(d) *Transition rules for counting creditable coverage.* An individual who seeks to establish creditable coverage for periods before July 1, 1996 is entitled to establish such coverage through the presentation of documents or other means in accordance with the provisions of § 2590.701-5(c). For coverage relating to an event occurring before July 1, 1996, a group health plan and a health insurance issuer are not subject to any penalty or enforcement action with respect to the plan's or issuer's counting (or not counting) such coverage if the plan or issuer has sought

to comply in good faith with the applicable requirements under § 2590.701-5(c).

(e) *Transition rules for certificates of creditable coverage*—(1) *Certificates only upon request.* For events occurring on or after July 1, 1996, but before October 1, 1996, a certificate is required to be provided only upon a written request by or on behalf of the individual to whom the certificate applies.

(2) *Certificates before June 1, 1997.* For events occurring on or after October 1, 1996 and before June 1, 1997, a certificate must be furnished no later than June 1, 1997, or any later date permitted under § 2590.701-5(a)(2) (ii) and (iii).

(3) *Optional notice*—(i) *In general.* This paragraph (e)(3) applies with respect to events described in § 2590.701-5(a)(2)(ii), that occur on or after October 1, 1996 but before June 1, 1997. A group health plan or health insurance issuer offering group health coverage is deemed to satisfy § 2590.701-5(a) (2) and (3) if a notice is provided in accordance with the provisions of paragraphs (e)(3) (i) through (iv) of this section.

(ii) *Time of notice.* The notice must be provided no later than June 1, 1997.

(iii) *Form and content of notice.* A notice provided pursuant to this paragraph (e)(3) must be in writing and must include information substantially similar to the information included in a model notice authorized by the Secretary. Copies of the model notice are available on the following website—<http://www.dol.gov/dol/pwba/> (or call 1-800-998-7542).

(iv) *Providing certificate after request.* If an individual requests a certificate following receipt of the notice, the certificate must be provided at the time of the request as set forth in § 2590.701-5(a)(2)(iii).

(v) *Other certification rules apply.* The rules set forth in § 2590.701-5(a)(4)(i) (method of delivery) and § 2590.701-5(a)(1) (entities required to provide a certificate) apply with respect to the provision of the notice.

[62 FR 16941, Apr. 8, 1997; 62 FR 31693, June 10, 1997]